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MENTAL HEALTH IN ONTARIO

A REPORT FOR
THE COMMITTEE ON THE MENTAL HEALTH
1970





ONTARIO

MENTAL HEALTH IN ONTARIO

C. HANLY

**A STUDY FOR
THE COMMITTEE ON THE HEALING ARTS
1970**

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FOREWORD

The Committee on the Healing Arts was established by the Province of Ontario, Order in Council 3038/66, dated July 14, 1966.

In June 1967, the Committee commissioned Professor C. Hanly, Department of Philosophy, University of Toronto, to undertake a study of mental health professions and services in Ontario. The following is a study prepared by Professor Hanly and submitted to the Committee in October 1968.

The statements and opinions contained in this study are those of Professor Hanly, and publication of this study does not necessarily mean that all the statements and opinions are endorsed by the Committee.

I. R. Dowie, Chairman
Horace Krever
M. C. Urquhart

ACKNOWLEDGEMENTS

I wish to acknowledge the work of three research assistants who contributed to this study: Phyllis Centner, Jenny Wong, and William Christian. I am also indebted to David McGowan of the Health Data Centre for the solution of many problems of data processing and, especially, for his work on the OMSIP study. The Health Data Centre of the Department of Health was very helpful, as was the Yale University Computer Center in accomplishing the computer analysis of survey research results. I am especially grateful to the many persons who answered questionnaires and granted interviews to myself and my research assistants. It is hoped that in return this study will make a contribution to the healing work of the mental health professions.

C.H.

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INTRODUCTION

Values and Objectives

The argument of this study is focused on three questions. The first, philosophical in nature, will be considered briefly in this introduction. It concerns what are believed to be legitimate goals for society in the field of mental health. The choice of these goals affects estimates of the adequacy of professional institutional resources for the care and cure of the mentally ill. The second question, the appraisal of the prevalence of mental illness in Ontario, will be elaborated in Part One of the study. The third question, concerning the nature of the physical and professional resources available to treat and care for patients suffering from different forms of mental illness, is discussed in Parts Two and Three. The conclusions of Part Four are based on the detailed analysis of each question.

Two Views on Goals

Athenian democracy was the first democratic society created by man in his search for socio-political organizations that would maximize the prospects for his survival and self-enrichment. Its philosophers advocated that a healthy mind in a healthy body was essential to an individual's fulfilment of his obligations to society and to his achievement of personal happiness. If we adopt this ideal, we are committed to the view that everything possible must be done within the limits imposed by science, technology, manpower and money to make every citizen as healthy in mind as his constitutional endowment and life experience will permit. Thus, given that we now have what the Greeks did not have — an organized body of knowledge yielding techniques for the treatment of mental illness — we cannot be content with anything less than the maximum utilization of available therapies whenever their application has some prospect of success. If, for example, there is a need for preventive mental health work among school children, we ought to train enough therapists to carry it out effectively and thoroughly.

The opposite view is that society should guarantee only such care and treatment services as are necessary to deal with disorders which actually endanger the safety of the individual who is sick or of persons with whom he is in contact. The specific nature of the danger will vary. It may be mental incompetence, arising from brain disorder; recurrent psychotic behaviour; addiction to drugs or alcohol; sexual perversion; or psychopathic violence. Or it may be a severely disabling

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neurotic disturbance. But in each case the actual impairment of an essential capacity, or recourse to dangerously anti-social behaviour determine the extent of therapeutic services which society should provide.

This view assumes that for the most part nature and the familial and social environments will together accommodate minor individual aberrations. Only a relatively small segment of the population (not much larger in number than those who are in treatment or in care in an institution at any given time) is deemed to require specialized mental health services. While it is recognized that numerous other persons may not be altogether free of psychogenetic symptoms, or may not be fulfilling their potential as spouses, parents, employees, professionals, businessmen or citizens, it is believed that there is no need for improvement and expansion of resources to help these people. For example, as long as the bread-winner of a family is gainfully and legally employed in a job that enables him to support his family, it is of no concern to society how he is employed or how personally satisfying his job is. Society is concerned only if he becomes incapacitated by mental illness, or is threatened with an incapacity that could cause his family to become dependent on the community for support. Similarly, no health resources need be made available to the housewife who keeps her marriage intact and looks after her children, even if her performance is barely adequate, unless she begins to develop suicidal tendencies or some other equally threatening symptom. Thus breakdown, and the imminent danger of breakdown, are the only appropriate criteria for selecting the psychiatric disorders which require deliberate mobilization by society of its institutional and professional resources.

There are arguments against both points of view. The first position is utopian. It is to be hoped that every individual would want to aspire to achieving a healthy mind in a healthy body. But given existing scientific, technical, institutional, financial and human resources, it is unrealistic to premise public social planning, as distinct from private personal planning, on the attainment of such an ideal state.

The fact of limited resources, especially professional resources, will be documented in the body of this study. Suffice it here to cite a few examples. R. G. Berry, in a recent manpower survey, has found that existing community and Department of Health mental health services have fifty-one vacancies for psychiatrists, sixty-five for psychologists, ninety-five for social workers, and thirty-three for psychometrists. These vacancies are for established positions, not for positions created by new treatment and care programs. For example, the Ontario Hospital at Goderich, which serves the counties of Huron and Perth, requires three senior and two junior psychiatrists to fully utilize available hospital and clinical facilities; the psychiatrists' facilities built into the Owen Sound General Hospital have never been used because no qualified professional staff are available. Also, there are too few psychiatrists in private practice and in mental health clinics. A number of general practitioners who were surveyed took the opportunity provided by the comments section of the questionnaire to state that they had no psychiatrists or

psychiatric facilities of any kind within the boundaries of their practice, or that these services were in such short supply that referrals involved long waiting periods. In the light of existing manpower shortages, it is likely that adequate care and treatment for only seriously disabling and chronic illnesses will be available in the immediate future.

Nevertheless, for several reasons, it would be unrealistic to limit planning and resource development to a minimal objective — namely, the diagnosis, care and treatment of only the most severe, most disabling and chronic illnesses.

The minimal approach essentially would require provision of hospital services for the severely mentally ill. But mental hospitals will always encounter the difficulty of attracting sufficient numbers of the most able physicians, psychiatrists, psychologists, social workers and nurses. Further, modern hospital psychiatry is being moved by its leading practitioners in the direction of a short-term emergency service, which is supported on both sides by strengthened preventive and rehabilitative services provided by outpatient clinics, hostels and private practices. Thus, a narrow focus upon the provision of hospital services for the most severe mental illnesses would arrest the development of much needed preventive and rehabilitative services. Moreover, hospitalization is necessary for only a small fraction of the total number of persons who need specialized mental health services. These other patients can be treated effectively and economically through attendance at a clinic or at the office of a private practitioner. Only if the mental health professions offer a wider range of opportunities will they attract more qualified people. Thus, a policy that is narrowly limited to the provision of hospital services is both inadequate in scope and self-frustrating, because it will not lead to the creation of the best possible hospital services. It is for these reasons that the minimal objective for the provision of mental health services is deemed to be unrealistic.

This conclusion has been confirmed strikingly by the recent research conducted by W. E. Powles and reported to the Ontario Psychiatric Association on February 1, 1969. Dr. Powles found that Canadian-trained physicians with an interest in psychiatry have gone to the United States for psychiatric training, because American schools provide opportunities in psychodynamics (psychoanalysis and psychotherapy), while Canadian schools emphasize general psychiatry (chemotherapy, electroshock, counselling and community psychiatry). That is, Canadian training is oriented strongly towards mental hospital psychiatry. Having been trained in the United States, these physicians tend to remain there to practise, in part because of the greater range of practice opportunities available. In order to retain and recapture these men and women, Canada must offer similar opportunities. Hospital psychiatry alone is not enough.

The development of private practice and community mental health clinics could have a strong impact on the care and treatment problems with which the Ontario mental hospitals and the psychiatric services of general hospitals have to

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cope. In the first place, remedial intervention and intelligent management of nascent illness could prevent some of the mental breakdowns that result in the need for hospital or custodial care. Second, since the hospitals and their clinics are training settings for all mental health professions, they would gain increased numbers of advanced trainees, thus reducing staffing problems at junior levels. Third, adequate rehabilitative services involving long-term post-hospitalization treatment could reduce the number of hospital readmissions. Consequently, in order to perform well the functions to which we are now committed, we will have to expand our services much further.

In conclusion, our realistic goal falls somewhere between the utopian maximum and the traditional minimum. Persons who have first-hand experience with the day-to-day problems of improving and expanding psychiatric and mental health services disagree as to where the goal should lie between these extremes, but few advocate either the maximum or the minimum objectives. In this study we accept the intermediate view as our guideline.

The major portions of the study consist of two factual and descriptive parameters: need and resources. But before we turn to these, we must deal with one more preliminary matter.

Definition of Terms

A number of basic terms have already been used — such as “mental health professions”, “psychiatry” and “psychiatric services” — and others will appear later in the study. It is useful to establish here certain general usages of these within our report.

“Mental illness” has two quite distinct meanings — one informal and one formal — as measured by connotation and scope of denotation. Popularly, “mental illness” is most often equated with insanity, or whatever it is that causes an individual to “lose his grip” and behave so strangely or violently that he must be hospitalized. This is the “strong” or narrow use of the term. In scientific usage, mental illness refers to psychotic and grossly impairing neurotic illnesses. For example, in a leaflet distributed by the National Association of Mental Health in the United States, mental illness is described as “a name covering several sicknesses of the mind which affect the way a person thinks, feels and behaves. The medical term for serious mental illness is ‘psychosis’. The legal term is ‘insanity’.”¹

There is a popular usage of the term “mental illness” that includes insanity and also much more broadly chronic states of unreasonable apprehensiveness, unusual difficulties in recovering from an object loss, and other kinds of impaired functioning associated with depression or anxiety. A person is also said to be

¹Quoted in *The Stirling County Study of Psychiatric Disorder and Sociocultural Environment*, Vol. III, Basic Books, New York, 1963, p. 136.

"sick", meaning "mentally ill", if he is thought to take pleasure in abnormal sexual practices, or if he exhibits sadistic or masochistic behaviour. This is the "weak" or wide informal use of the term. It too has a correlate in scientific usage when it is used synonymously with disturbances of personality, ranging over a scale of seriousness from the impairment of brain damage and severe psychosis through personality disorders and psychoneurosis, to psychophysiological symptoms.

This last usage corresponds with the concept of psychiatric disorder as developed by A. H. Leighton in the first volume of *The Stirling County Study of Psychiatric Disorder and Sociocultural Environment*.² It is consonant also with the comments received via the questionnaire to psychiatrists concerning the diagnostic classification of mental illnesses. The respondent who found the gross categories enumerated in the questionnaire inadequate was invited to elaborate his preferred categorization. A representative critical comment was the following: "All categories are meaningless. In practice I do not diagnose, as such, but attempt to estimate the degree of deviation (illness) from the norm which is 0. Level 1 contains all so-called "nervous" people (most of these do not come to treatment). Neuroses are roughly level 2; character problems, roughly level 3; psychoses, roughly level 4; and suicide, roughly level 5." Comments by other psychiatrists suggested that the principal reason for dissatisfaction with the standard classifications is that clear-cut cases of specific textbook syndromes are observed only infrequently, and symptom patterns tend to change in the course of treatment.

Defining mental illness in terms of the degree of deviation has the advantage, too, of being more compatible with the categorical preferences of psychologists and social workers, the professional partners of psychiatrists in the care and treatment of mentally ill persons. Most psychologists object to psychiatric categorization of mental illnesses into species of psychoses, neuroses, and character and behavioural disorders. They regard the subject (patient) as being in a "problem situation" — he may, for example be faced with under-achievement, delinquency, criminality, confused self-identity, familial problems, lack of career goals, and so on. Psychologists use the term "assessment" more often than "diagnosis" for their analysis of these "problem situations", including the liabilities and capabilities of the subject. Social workers are more likely to employ the terminology of standard psychiatric classifications in assessing a client's inability to function normally and

²For a more detailed account see *ibid.*, pp. 14, 117, 135, 136, 355. The author's definition is being followed here. It is comparable to the definition used by the authors of L. Srole et al., *Mental Health in the Metropolis*, McGraw-Hill, New York, 1962. The classification of psychiatric diagnoses used for questionnaires and interview design was taken from the World Health Organization classification which is used by the Ontario Medical Services Insurance Plan, the Ontario Department of Health and the Dominion Bureau of Statistics. For a discussion of some of the difficulties in establishing a universally acceptable system of classification see "Epidemiology of Mental Disorders", *World Health Organization Technical Report Series*, No. 185, World Health Organization, Geneva, 1960, pp. 16-19.

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his need for psychiatric services. However, the basic orientation of social workers to their clients is guided by the "problem situation", functional approach.

Diagnostic categories are uncertain mainly because it has proved extremely difficult to establish an exact etiologically based classification of symptoms. Leighton's summary of the etiology of varieties of mental illness (which is representative of current classifications) is worth quoting at length, for it clearly reflects this problem.

Heredity — *predominant in*: personality disorder, psychotic disorders and mental deficiency; *plays some part in*: psychoneuroses, sociopathic disorders, psychophysiological disorders and brain syndromes.

Physiological factors — *predominant in*: brain disorders; *plays some part in*: psychoneuroses, personality disorders, sociopathic disorders, psychophysiological disturbances, psychotic disorders and mental deficiency.

Psychological experience — *predominant in*: psychoneuroses and psychophysiological disorders; *plays some part in*: personality disorder, sociopathic disorder, psychotic disorders, mental deficiency and brain disorder.³

In this report, consistent with our choice of goals, we have used the term "mental illness" to include all conditions in levels 1-5 described in the psychiatrist's comment above. This usage is applied also to the term "psychiatric disorder" employed in the Stirling County and Midtown studies.⁴

The following quotation from F. C. Redlich shows the connection between society's goals and the definition of mental illness. It also explains why no attempt has been made to define the extent of facilities, beyond minimal services, that should be set as a goal.

One of the more striking differences (between serious and minor disorders) is the degree of urgency for treatment, which is usually greater in the case of the severe illnesses as compared with the mild disorder; sometimes a situation is found in which there is acute danger for the life and safety of the patient or those who are in contact with him. Intervention is often demanded so urgently that treatment and usually hospitalization is mandatory Co-operation from the patient in such a process is thought to be desirable but not necessary. There is the assumption that such a step is necessary both from the patient's and from society's point of view, even if patients are not capable of, or willing to, recognize it In the severe cases, psychiatric help is, theoretically at least, available to all who need it. When psychiatrists and psychiatric facilities do not exist, as in certain geographic areas, the lack of psychiatric help is felt as seriously as the lack of other medical personnel, facilities and supplies In the moderate disturbance and in the near-normal case, for which we have no name, there is no such urgency or such degree of obligation to submit to treatment. The agreement between patient and psychiatrist is voluntary and informal, except

³A. H. Leighton, *My Name is Legion*, Basic Books, New York, 1959, pp. 15, 124.

⁴*Ibid.*, p. 122.

for the general rules which apply to all relationships with medical practitioners. In comparison with treatment of the severe disorders, the treatment of the moderate group is considered less essential by society and to a certain extent still has the characteristics of a "luxury" for the upper classes who can afford and appreciate it. However, there is change too, both in a broader appreciation and in greater availability of such treatment to the less privileged classes.⁵

It follows that "breakdowns", ranging from the complete incapacitation of the individual to his being impaired to some significant degree in his ability to function in the community, form the most serious part (though not the whole) of mental illness. Thus, the term "mental health field" includes all activities from research to custodial detention, care, treatment and education designed to remedy or find ways of remedying any pathology in this range. Also, the term "mental health profession" includes any profession that by training and utilization of training equips individuals to perform any of the wide variety of tasks designated above: it is comprised of psychiatrists, psychoanalysts, clinical psychologists, psychometrists, psychiatric social workers, psychiatric nurses, child care workers, and mental health educators, aides, orderlies and custodial officers. More specific definitions of these categories will be given where appropriate.

Data Collection Methods

The information and points of view presented in this report were derived from four sources: field work; questionnaire surveys; data collected on the Ontario Medical Services Insurance Plan claim cards and stored on their computer tapes; and the literature relating to the various subjects and problems under review, including briefs and supporting documents presented to the Committee on the Healing Arts. The field work, undertaken by the author and four research assistants, was done for the most part during July and August of 1967, although additional work was done during the autumn and winter of 1967-1968. It consisted of three sets of interviews:

- 1) Interviews with representative members of the various mental health professions in a variety of different settings (Ontario hospitals, general hospitals, clinics, private practice, universities, and so on).
- 2) Interviews with mental health professionals involved with specific problem areas (for example, treatment of emotionally disturbed children, mental health services in the schools, forensic psychiatry, psychological services in reform institutions, alcoholism and drug addiction).
- 3) Interviews with mental health professionals in jurisdictions outside Ontario (New Haven, Boston, New York and Montreal).

⁵F. C. Redlich, "The Concept of Health in Psychiatry", in A. H. Leighton, John A. Clausin and Robert N. Wilson (eds.), *Explorations in Social Psychiatry*, Basic Books, New York, 1957, pp. 155-157.

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The interviews were organized to survey: 1) the major functional roles of the professions involving treatment, education, research and administration; 2) a variety of diverse socio-economic regions — metropolitan, urban and rural.

A questionnaire survey of psychiatrists, psychologists, general practitioners, general surgeons, orthopaedic surgeons, internists, obstetricians and gynaecologists, and neurologists was conducted, as well as a questionnaire survey of chairmen of Departments of Psychology in Ontario's universities, school boards, university health services, inpatient facilities and outpatient clinics. The data received from the questionnaires to physicians and psychologists was coded, key punched, and subjected to computer tabulation and analysis, with the assistance of the Health Data Centre, Department of Health, Toronto, and Yale University, New Haven.

The basic facts concerning the questionnaire surveys are summarized in the following table.

Questionnaire	Number sent	Number returned	Number used
Psychology	400	197	177
Psychiatry	486	161	150
General practice	1,000	298	273
General surgery	480	141	126
Orthopaedic surgery	110	33	28
Neurology	196	43	31
Internal medicine	578	153	130
Obstetrics and gynaecology	347	78	71
Chairmen, Departments of Psychology	11	10	10
School boards	56	44	44
University health services	16	7	7
Inpatient facilities	45	31	31
Outpatient clinics	37	28	28

The discrepancy between the number returned and the number used had a number of causes. In the case of psychiatry, the Ontario Medical Association mailing list was used. This is an "open list", in that persons who are not certified psychiatrists can be placed on it. A few returns were rejected because the respondent was neither a certified psychiatrist nor a senior resident in psychiatry. Others were rejected because the respondent had retired from active practice. These questionnaires were studied for the comments they contained and the attitudes reflected in responses made, but were not included in any tabulations. Responses from other practitioners were rejected if the respondent commented that he had been unable to answer with any confidence. A few were rejected because they were highly idiosyncratic (for example, a general practitioner reported that in a typical week he diagnosed fifty patients as being psychotic!). Others were rejected because of a variety of defects in the data, such as incon-

sistency or inadequate definition of terms. Many respondents took the trouble to supply helpful comments concerning the psychiatric content of the practice, with useful suggestions concerning changes that they would find helpful. The questionnaires asked for estimates as far as numerical data were concerned. Copies of the questionnaires and some further comments on them are to be found in an appendix to this study. Similar reasons apply to the exclusion of some of the psychology questionnaire returns from the tabulations.

The following titles have been adopted for these questionnaire surveys, the results of which appear throughout this report:

Hanly Study 1	OMSIP	Diagnostic Data Analysis
Hanly Study 2	Mental Health Survey:	Psychiatrists
Hanly Study 3	Mental Health Survey:	Physicians
3a	:	General Practitioners
3b	:	General Surgeons
3c	:	Orthopaedic Surgeons
3d	:	Neurologists
3e	:	Internists
3f	:	Obstetricians and Gynaecologists
Hanly Study 4	Mental Health Survey:	Psychologists
4a	:	Registered Psychologists
4b	:	Chairmen of University Departments of Psychology
Hanly Study 5	Mental Health Survey:	School Boards
Hanly Study 6	Mental Health Survey:	University Health Services
Hanly Study 7	Mental Health Survey:	Inpatient Facilities for Children
Hanly Study 8	Mental Health Survey:	Outpatient Facilities for Children

Part One: The Mental Health Problem in Ontario

One of the first problems to present itself in our study was the lack of any data concerning the prevalence of mental illness in Ontario. Without such data it is impossible to measure the adequacy of current services or to design optimally beneficial new services. One might suppose that the Department of Health would have long since established such studies, but such is not the case. The Department of University Affairs and the universities are constantly reviewing data on projected enrolment as a means of defining the quantity and type of university places needed ten years hence; the same approach is needed in mental health. In the light of existing deficiencies, an effort was made to provide some crude estimates of need and to lay some of the ground work for improvements in the measurement of need.

Chapter 1 An Analysis of some of the Epidemiological Literature

Methods: Prevalence vs. Incidence

The scope of the mental health problem in Ontario can be measured in terms of either incidence or prevalence. A measure of incidence provides estimates of new illnesses over a period of time. A measure of prevalence provides estimates of persisting and new illnesses.¹

Incidence or prevalence estimates can be made in three ways: 1) by taking a census of all persons who are in treatment for mental illnesses in the hospitals, clinics, residential treatment centres, service agencies and private practices in the province on a given day; 2) by surveys such as those of the Stirling County Study and the Manhattan Studies; 3) by surveys of the opinions of practitioners in the mental health field.

The advantage of the first method is that it is relatively simple. Data can be utilized that are collected routinely by the Department of Health and Dominion Bureau of Statistics from hospital records; data from private clinics and practices, however, are not as readily available. But an estimate of incidence based on this method is unacceptable for the specific purpose of this report — to determine the scope of the need for mental health services as a means of measuring the adequacy of existing services. For it is logically fallacious to use a census of persons actually coming into treatment to evaluate the quantitative adequacy of available resources. This is not to deny that the *supply* of treatment services made available in the province will be influenced in the long run by the pressures of need and the *demand* for services. However, if the supply of services is *below* current demand level, then a patient census will necessarily reflect *supply level* rather than *demand level* — let alone *need level*, which in the case of psychiatric illnesses will almost certainly not be reflected accurately in demand. Consequently, patient census figures are useless for the purpose of estimating the extent of need for psychiatric services in a community.

Underestimation of Need for Treatment

It has been suggested that the need for psychiatric treatment is greater than the demand. That such is indeed the case is indicated by an analysis of OMSIP data

¹A critical analysis of the value of incidence as compared with prevalence estimates is to be found in L. Srole et al., *The Midtown Manhattan Study*, Vol. 1, McGraw-Hill. New York, Appendix C, pp. 380-382.

concerning the reporting by physicians of the diagnosis of alcoholism. The existence of a strong constraint on realism and honesty in the reporting of the diagnosis of alcoholism by physicians (as evidenced by the OMSIP data in Table 1.1) is undoubtedly associated with a similar constraint on the reporting of psychiatric problems.

TABLE 1.1

**Alcoholism Diagnosis Reporting on Ontario Medical Services Insurance Plan
Claim Cards, May 1–October 31, 1967**

Nature of problem	Type of physician	Number of services rendered	Number of patients receiving services
Alcoholic	All	91	38
Psychiatric	All	216,020	52,108
Other than alcoholic or psychiatric	All	3,538,343	712,335

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967.

It is known that there are approximately 100,000 persons suffering from alcoholism in Ontario. The basis for this figure is given in Chapter 16 of this report. The population of the OMSIP study was close to 17 per cent of the total population of Ontario; this means that it is probable that at least 17,000 persons in the study population were suffering from alcoholism. This probability is moved upward towards certainty once one takes into account two additional factors. First, all persons on welfare in the province are enrolled automatically in OMSIP, and the premiums of low income subscribers are supported in part or entirely depending on the financial need of the subscriber. Second, alcoholism is associated with loss of income. Hence, it is very likely that in the categories of welfare and assisted OMSIP subscribers there are more alcoholics than our projection postulates — i.e., that our figure is on the conservative side. Consequently, despite the fact that physicians dislike treating alcoholism, it is altogether unlikely that only 38 members of the OMSIP study population presented themselves to physicians during the six-month period of the study with symptoms produced by alcoholism. An unknown additional number of alcoholics are buried among the 712,335 persons who were given some other diagnosis. It is not difficult to explain how doctors avoid a true diagnosis. They simply report a major symptom of the disease rather than the disease itself. The reason behind this substitution of a symptom for the illness is the social and moral stigma attaching to alcoholism.

There is a similar and perhaps even a more powerful stigma attaching to mental illness. Consequently, comparable efforts will be made to cover up, overlook or deny the existence of a mental illness. Since physicians are only carrying

out the demands of a widespread psychologically determined social pattern, we can safely conclude that demand for psychiatric treatment will be substantially less than the need for it.

Existence of Unserved Needs

The demand for service increases dramatically when new, improved services of quality are made available. Evidence of this has been found in Service Three, part of a new community mental health service for a catchment area in New Haven, Connecticut under the direction of Max Pepper, M.D. This area is of particular interest because it has already been a location for epidemiological studies.² Prior to the creation of Service Three, which was established under Public Law 88-164 in 1966, the same catchment area was served by the Connecticut Mental Health Centre at New Haven. The largest number of individuals seeking psychiatric help in the outpatient clinic was approximately 195, with an average of 160 over a number of years prior to 1966. In its first year of operation (1966) 325 persons sought psychiatric help through the expanded outpatient services of Service Three. By August 28, 1967, 300 persons had sought treatment, providing for a projection for the full year of approximately 700 of the area's population of 78,000. Psychiatric examination revealed that every person seeking help was, in fact, in need of treatment.

It is evident from these figures how underestimated the need for mental health services in the catchment area would be if the estimate were based on patient census figures prior to 1966. But the figures for 1966 or 1967 are not logically more accurate, despite the increases, because they still do not reflect unrecognized need.

A major factor in the increased utilization of the Service Three outpatient's clinic was a vigorous public education program undertaken by Dr. Pepper prior to the opening of the clinic. This campaign was designed to counteract the influence of the taboo against the acknowledgment of impairment from mental illness, as well as factors of socio-economic alienation which had inhibited the conversion of need into demand prior to 1966.³

Much more broadly based evidence of the same phenomenon is reported in the Annual Report of the British Ministry of Health for 1966. Statistics relating the expansion of facilities to the numbers of persons on waiting lists for psychiatric services show no proportionate decrease in the length of the waiting lists.⁴ On the contrary, the creation of new facilities encourages more people who need psychiatric help to seek it.

²A. B. Hollingshead and F. C. Redlich, *The New Haven Study*, Yale University Press, New Haven, 1958.

³Data derived from an interview with Dr. Pepper at New Haven, August 28, 1967.

⁴*Annual Report of the British Ministry of Health for 1966*, pp. 26-27.

Unfortunately, no particular or general expansion of mental health services has occurred in Ontario such as those in Service Three in New Haven and in Great Britain. Thus comparable data for Ontario are not available. A substantial majority of the Ontario psychiatrists interviewed were of the opinion, however, that our mental health services do little more than make a good start at serving the most seriously impaired mentally ill. And, if allowance is made for the narrow limitations inherent in the data on which it is based, the following analytic comment from Volume I of the DBS *Mental Health Statistics* is instructive.

With the opening of new facilities, the group of patients served who are neither psychotic nor mentally defective may be weighted in favour of female psychoneurotics (especially neurotic-depressives) and males diagnosed under disorders of character and behaviour.⁵

In the light of Redlich's statement quoted earlier, this statistic means that an undetermined number of persons suffering from the less severe mental illnesses will quickly make use of any new services that are made available. Such persons do not seek treatment now primarily because facilities are limited. While there are serious drawbacks to the method of estimating need on the basis of a patient census, as we shall see below, these data provide grounds for concern about the adequacy of our services.

The only scientifically valid means of estimating need for facilities is by the population survey, the second method referred to above.⁶ In the context of this study, we lacked the time and resources to conduct this kind of investigation in Ontario. All that has been possible here has been a survey of some of the epidemiological literature that reports studies of this type conducted elsewhere. Three such studies have been selected for special attention: first, because they employ similar methods and criteria; and, second, because they involve populations that are comparable to the population of Ontario in their demographic heterogeneity.

The three studies selected are the Stirling County Study, the Midtown Manhattan Study and the Health Survey of Heyfield, Victoria.

Population Survey Studies

Stirling County Study

The Stirling County Study investigated the prevalence of mental illness (psychiatric disorder) in the population of a coastal county of Nova Scotia containing French Canadians (St. Malo area) and English Canadians (Windsor area). The major occupations of the people were fishing, farming and lumbering, and jobs in associated industries and services. One of the aims of the study was to determine the socio-cultural correlates of mental illness.

⁵DBS, *Mental Health Statistics*, Vol. I, Queen's Printer, Ottawa, 1964, p. 20.

⁶See p. 11.

The study was conducted by an interdisciplinary team of psychiatrists, psychologists, social scientists and mathematicians based at Cornell University in collaboration with Dalhousie and Acadia Universities. Canadian financial support (part of the total budget) came from the Department of National Health and Welfare and the Nova Scotia Department of Public Health. Data were obtained in three principal ways: 1) by a questionnaire administered by a two-hour interview of a sample of the population of the county; 2) by impressions obtained from physicians and community sources; 3) by more detailed studies of individuals and families in subregions of the county who made use of the services of a general practitioner and a community mental health clinic.

The prevalence figures for mental illness in the Stirling County Study are shown in Table 1.2. Approximately 57 per cent of the population of the county were suffering from a psychiatric disorder or had suffered from one during their lifetime. However astonishing and interesting this figure is in itself, it is not the most important one for our purposes, since it involves no measure of severity and, hence, gives no indication of the urgency of need for treatment.

The essential finding of the Stirling County Study pertinent to the particular concerns of this report combines prevalence with impairment, as shown in Table 1.3.

TABLE 1.2
Prevalence of Psychiatric Disorder in Stirling County Estimated from the Family Life Survey at the Medium Level of Information

Rating	No. of respondents receiving this rating	Weighted percentage of respondents receiving this rating	Estimated probability that an individual receiving this rating would, if intensively studied, prove to be a genuine psychiatric case	Estimated percentage of adult population who (a) receive this rating and (b) are genuine psychiatric cases
A	313	30.5	.9	28
B	260	24.6	.7	17
C	261	26.2	.4	10
D	176	18.7	.1	2
Total	1,010	100.00		57

SOURCE: D. C. Leighton, J. S. Harding, D. B. Macklin, A. M. Macmillan and A. H. Leighton, "Family Life Survey of Stirling County", in *The Character of Danger*, Basic Books, New York, 1963, p. 121. Based on a total sample of 1,150 members of the Stirling County community in Nova Scotia.

TABLE 1.3
Prevalence of Psychiatric Disorder with and without Significant Impairment,
Estimated from the Stirling County Family Life Survey
(Medium Information)

Rating	Weighted percentage of res- pondents receiving this rating	Estimated percentage of adult population who receive this rating and are genuine psychiatric cases with significant impairment	Estimated percentage of adult population who receive this rating and are genuine psychiatric cases with negligible impairment	Estimated percentage of adult population who receive this rating and are not genuine psychiatric cases
A	30.5	17	11	3
B	24.6	6	11	7
C	26.2	1	9	16
D	18.7	0	2	17
Total percentage	100.0	24	33	43

SOURCE: D. C. Leighton et al., "Family Life Survey of Stirling County", in *The Character of Danger*, Basic Books, New York, 1963, p. 129. Based on a total sample of 1,150 members of the Stirling County community in Nova Scotia.

Some explanations of the data are in order. "Medium information" refers to the *quantity* of data available from the survey on which these figures were based, as compared with the greater amounts of data derived from the more regional studies — notably, from a survey of the residents of the municipality of Bristol, Nova Scotia. The results based on greater amounts of data reveal that substantially more persons suffered from a psychiatric disorder that caused significant impairment; it is thus suggested that the above figures tend to *underestimate* the amount of significant impairment from mental illness in the population. A "psychiatric case" is a person who "if thoroughly studied by psychiatrists, would be diagnosed as suffering from one or more of the specific psychiatric conditions" described in the American Psychiatric Association Diagnostic Manual. The A, B, C and D ratings are evaluations concerning the survey data. They represent the fact that the chances are better than eight, six, two and zero respectively that the individual concerned is or has been a psychiatric case. Statistical weighting relates the resulting figures to the total population of the county.

In sum, the Stirling County Study estimates "that 24 per cent of the people of Stirling County have suffered significant impairment from psychiatric disorder during their lives, while another 33 per cent have experienced psychiatric disorder

without significant impairment".⁷ The more intensive study of a smaller segment of the population yielded higher estimates: 42 per cent with significant impairment, and 27 per cent with negligible impairment.

Midtown Study

The Midtown Study was conducted along lines similar to those of the Stirling County Study. T. A. C. Rennie, the first director of the project, and his team of psychiatric colleagues take special care to calibrate the scale for the severity of symptom formation so as to make it congruent with their clinical experience of mentally ill patients. The calibration of the mental health data collected by means of questionnaires administered by interview on a sample of the Midtown population consisted of six gradients: well, mild symptom formation, moderate symptom formation, marked symptom formation, severe symptom formation, and incapacitated. Individuals in the last three classes were classified as impaired. The results of the study are summarized in Table 1.4.

TABLE 1.4
Home Survey Sample (Age 20-59), Distribution of Symptom-formation
Classification of Mental Health

	Percentage
Well	18.5
Mild symptom formation	36.3
Moderate symptom formation	21.8
Marked symptom formation	13.2
Severe symptom formation	7.5
Incapacitated	2.7
Impaired	23.4
N = (1,660) 100%	

SOURCE: L. Srole, T. S. Langner, S. T. Michael, M. K. Opler and T. A. C. Rennie, *The Midtown Manhattan Study*, McGraw-Hill, New York, 1962. Based on a home interview survey of 1,660 Midtown Manhattan adults.

The study shows that 23.4 per cent of the Manhattan population were impaired in their capacity to work and to form adequate basic relationships. The degree of impairment varied, but in all cases it was thought sufficient to create the need for treatment.

Heyfield Study

The third and final study to be cited was conducted in the community of Heyfield, Victoria, Australia.⁸ Again, similar methods were employed, although somewhat

⁷D. C. Leighton et al., "Family Life Survey of Stirling County", in *The Character of Danger*, Basic Books, New York, 1963, p. 131.

⁸J. Krupinski, A. G. Baikie, A. Stoller, J. Graves, D. M. O'Day and P. Potke, "A Community Health Survey of Heyfield, Victoria", *The Medical Journal of Australia*, No. 1, 1967, p. 1204.

different criteria for the definition of symptoms were adopted from those used in the Stirling County study. Obesity, hay fever, asthma and allergic disorders were classified as medical rather than psychiatric diagnoses in the Heyfield Study, whereas they were treated as psychophysiological symptoms in the Stirling County Study. In contrast with the Midtown Study, the Heyfield Study surveyed all types of health problems, its two most general categories being medical and psychiatric diagnoses. The results are presented in Tables 1.5 and 1.6.

TABLE 1.5
Medical and Psychiatric Diagnoses Made

Age-sex category	Persons interviewed		No medical or psychiatric diagnosis		Medical diagnosis alone		Medical and psychiatric diagnosis		Psychiatric diagnosis alone	
	No.	%	No.	%	No.	%	No.	%	No.	%
Children	756	100	489	65.9	175	23.1	27	3.6	56	7.4
Male										
adolescents	122	100	62	50.8	40	32.8	5	4.1	15	12.3
Female										
adolescents	119	100	39	32.8	57	47.9	19	16.0	4	3.3
Male adults	461	100	115	24.9	241	52.3	77	16.7	28	6.1
Female adults	398	100	62	15.6	222	55.7	97	24.4	17	4.3
Elderly	73	100	8	10.9	52	71.3	10	13.7	3	4.1
Total	1,929	100	784	40.6	787	40.8	235	12.2	123	6.4

SOURCE: J. Krupinski, A. G. Baikie, A. Stoller, J. Graves, D. M. O'Day and P. Potke, "A Community Health Survey of Heyfield, Victoria", *The Medical Journal of Australia*, No. 1, 1967, p. 1204.

The investigators summarized their results as follows:

Major mental illnesses were found in only 1.5% of the population. Altogether 18.6% of the population suffered some degree of psychiatric disability, and of these 12.2% had an associated physical disorder.⁹

The three studies are notably consistent in their results relating to the question that is of greatest interest to us — what percentage of the population is disabled to a serious degree by a mental illness. The Stirling County Study provides the highest figure of 24 per cent, the Midtown Study figure is only a fraction lower, 23.4 per cent; and the Heyfield Study is lowest at 18.6 per cent. The discrepancy between the highest and lowest figures perhaps can be accounted for by the much longer prevalence period adopted in the Stirling County Study (now or ever) as compared with the Heyfield Study (currently). But the Midtown Study prevalence period was comparable to that of the Heyfield Study, and the percentage figure of Midtown for disability was very close that for Stirling County.

⁹*Ibid.*, p. 1205.

TABLE 1.6
Psychiatric Symptoms and Diagnoses

Age-sex category	Persons without psychiatric diagnosis or neurotic symptoms		Persons with organic brain disease, functional psychosis or mental retardation		Persons with other psychiatric diagnosis		Persons with neurotic symptoms (no diagnosis)	
	No.	%	No.	%	No.	%	No.	%
Children	380	48.9	9	1.2	74	9.8	293	40.1
Male adolescents	46	37.7	2	1.6	18	14.8	56	45.9
Female adolescents	24	20.2	3	2.5	20	16.8	72	60.5
Male adults	109	23.7	5	1.1	100	21.7	247	53.5
Female adults	49	12.3	4	1.1	110	27.6	235	59.0
Elderly	12	16.4	6	8.2	7	9.6	48	65.8
Total	620	32.1	29	1.5	329	17.1	951	49.3

SOURCE: J. Krupinski et al., "A Community Health Survey of Heyfield, Victoria", *The Medical Journal of Australia*, No. 1, 1967, p. 1204. Based on a sample of 1,929 of the residents of all ages of Heyfield, Victoria, Australia.

Two further considerations are pertinent. The Stirling County Study strongly suggests that spontaneous remission of symptoms in the sense of a marked reduction in the degree of impairment from an untreated psychiatric disorder is a relatively uncommon phenomenon. Consequently, the estimate of the prevalence of mental illness based on the prevalence period — now or ever — is likely also to approximate the estimate based on the prevalence period — currently.¹⁰ What, then, accounts for the discrepancy? Both the Manhattan Study and the Stirling County Study base their findings on the adult population (Manhattan Study, ages 20-50; Stirling County Study, heads of households). If we derive the figures for the comparable age groups from the Heyfield Study, we get a result of 25.7 per cent disability for adults only, and 23.3 per cent for adults and elderly; prevalence of mental illness among children and adolescents was found to be substantially lower than for adults. Thus, when the populations of these three independent studies are made homogeneous with respect to age, a remarkable agreement emerges among them concerning the prevalence of significant impairment from a psychiatric disorder. This agreement is especially important because the studies were conducted by different research teams and they involved three geographically, economically and socially diverse populations, one of which happened to be Canadian.

¹⁰D. C. Leighton et al., *op. cit.*, pp. 118-119.

Relevance of Findings to Ontario

One must exercise caution in deriving generalizations about the Ontario population from these studies. However, the following line of reasoning seems justified. In the section which he contributed to the Manhattan Study, Srole considers the possibility that the results were exaggerated either by the fact that the population studied contained an unusual amount of psychiatric pathology, or by the fact that the morbidity range adopted was excessively broad relative to clinical standards. Srole presents convincing reasons for rejecting both possibilities. It follows that Srole's result will probably prove to hold true for the whole American population.¹¹ This probability is increased by the consistency of the results of the two additional studies examined here.

When considering the problem of generalizing to Ontario's population, these factors seem pertinent: 1) the population studied in Stirling County is similar to Ontario's rural population with respect to employment, physical environment and culture; 2) the Midtown population is at least somewhat similar to Toronto's core metropolitan population; 3) the Heyfield population, composed as it is of native-born Australians and postwar British and European immigrants, is comparable to those of Toronto suburban and large town populations in Ontario. These similarities can be easily exaggerated, but our inference is reasonable. The consistency of the results indicates that genetic endowment, the quality of family life, and the anxiety and stress to which people are subjected by their natural and socio-economic environments (such as education, unemployment, natural occupational hazards, rapid socio-economic change) are the most important determinants of mental health or illness. These factors appear to be more influential than superficial demographic features, such as nationality, or urban or rural living. If we can assume that these factors are approximately equivalent between the studied populations and the various populations, urban and rural, of Ontario, then it is probable that approximately 20-25 per cent of Ontario's population have suffered, are suffering, or will suffer from a psychiatric disorder sufficiently impairing to require treatment by a qualified professional in one or other of a number of different treatment settings.

Interpretation of Estimate

This conclusion is accepted by practising psychiatrists who have taken a special interest in the extension of mental health services to the community.¹² However, the estimate also encounters incredulity and resentment. The incredulity stems no doubt from the fact that we are the dupes of our own social masks. We too often and too easily believe that our social identities are the totality of our own persons. The estimate contradicts our commonsense, impressions and convictions. And the

¹¹L. Srole et al., *The Midtown Manhattan Study*, *op. cit.*, pp. 139-145, 150-151.

¹²For example, it is postulated by D. B. Coates in "Poverty and Mental Health", *Canada's Mental Health*, Vol. XV, Nos. 55 and 56, pp. 3-8.

incredulity can itself become a defence against the resentment aroused by the threatening question, "If one in every four or five persons suffers from significant psychological disability, how do I stack up?" Everyone would be quite comfortable if the estimate of impairment from psychopathology were one in fifty or even one in twenty (2-5 per cent of the population). But the much larger estimate sets off nagging self doubts in many people. These self doubts, because they are usually unconscious, can easily be transformed into resistance to increased public expenditure to expand and improve mental health services.

Nevertheless, it would be unwise to use the 20-25 per cent prevalence figure as a definition of need against which to measure the mental health resources of the province; for it is unlikely that the mental health needs of such a large number of people can be met in the foreseeable future. There are frequent reports in the daily press of programs to deal with juvenile delinquency, marital problems, alcoholism, and emotional disturbances in children, the success of which depends on the availability of mental health professionals for new programs and services. But, as will be demonstrated in succeeding chapters, there are not enough professional resources for existing programs. Therefore, while we do not reject the 20-25 per cent estimate, we cannot realistically use it in defining attainable goals for resource development. Let us then, without scientific or humanitarian justification but in the interests of what is practical, adopt the somewhat arbitrary objective of creating mental health resources in the province sufficient to diagnose and treat 10 per cent of the population. By this estimate 700,000 of Ontario's 7,000,000 population are assumed to be sufficiently disabled by a psychological disorder that treatment is desirable.

Those who remain skeptical about even this reduced objective may want to consider yet another type of statistic recently made available by the Dominion Bureau of Statistics. The DBS study shows that:

. . . of the total number of 19,644,000 persons (9,879,200 males, 9,764,800 females) living in Canada in 1965, 2,394,804 (1,256,925 males, 1,137,879 females) would be expected to be admitted to a psychiatric institution on at least one occasion during the remaining years of their lives (12.7% of the males, 11.7% of the females). The remaining 17,249,196 persons would not be expected to be admitted because (a) they will remain mentally healthy (b) they do not utilize the reporting inpatient facilities even though in need of treatment . . . (c) death will "rescue" them from admission to a psychiatric institution . . .¹³

These figures are no doubt conservative as measures of need, since they are based on incidence data derived from institutions reporting to DBS. Also, they project estimates of at least, and perhaps only, once-in-a-life-time admissions; hence, they do not indicate the scope of the need for hospital care and treatment

¹³DBS, *Mental Health Statistics: The Expectation of Admission to a Canadian Psychiatric Institution*, Queen's Printer, Ottawa, October 1968.

at any given time. Nevertheless, the DBS data support our view that psychiatric resources competent to diagnose and treat 10 per cent of the population are a *minimum* capability. Further support is provided by the facts that 1) mental illnesses of the severity requiring hospital admission are highly chronic, and 2) the DBS data do not include persons treated privately.

In a free, scientifically and technologically advanced society anyone who wants to seek a remedy for a psychopathological disability should have a reasonable prospect of finding the requisite services. The Midtown Study has shown that within the group of psychologically impaired persons (see Table 1.4, p. 17) 5.4 per cent were in treatment at the time of the study; 21.3 per cent had once been in treatment; 13.4 per cent had never been in treatment but revealed a desire for psychiatric treatment; another 15.7 per cent were either getting help, or showed an inclination to seek help, from some professional other than a mental health professional (such as a general practitioner, clergyman or social worker); and 44.2 per cent had never been patients and showed no sign of seeing in any professional a potential source of help. Consequently, taking into account the discrepancy between awareness of mental health services in New Yorkers as compared with Ontarians (because New York has had more and better services longer than Ontario), it seems reasonable to view the 10 per cent figure as approximating the level of potential demand for psychiatric services in Ontario where "demand" means "need plus willingness to seek professional psychiatric help".

Nature of the Demand Group

It is worth defining the nature of this demand group in some detail. First, it includes the "severe illnesses" noted by Redlich for which "treatment and usually hospitalization is mandatory". Within this subgroup are such illnesses as severe mental retardation, gross impairment from brain damage, severe psychosis, criminality associated with character disorders, and so on; those suffering from these illnesses now are or should be in hospital, in custodial care, or in intensive treatment at an outpatient clinic or with a private practitioner. Second, it includes severe psychoneurotic illnesses, milder forms of psychoses, and character and behaviour disorders which narrowly circumscribe the individual's functioning, produce highly distressful symptoms, and may result in hospitalization in the absence of treatment. Third, it includes individuals who are only threatened with loss of capacity or are less impaired than the second group, but who because of their business or professional commitments cannot afford to be mildly impaired or because of their philosophy of life and their self-awareness wish to realize their full potential. It is likely that the first segment of the demand group will remain constant as a percentage of the population over time; that the second group will increase slowly over time with the further dissemination of mental health knowledge; and that the third group will increase as rapidly as the availability of services and their cost will allow.

Other studies have estimated the prevalence of mental illness at a figure as low

as our reduced figure. The Baltimore Study,¹⁴ for example, concluded that 10 per cent of an urban population are, at any given time, mentally ill. But two facets of the Baltimore study must be placed in perspective. First, its purpose was to determine the prevalence of chronic disease of all kinds and its variation with social and economic status; that is, it was not designed specifically to determine the prevalence of mental illness. Second, the 10 per cent figure was deemed by the researchers to be conservative, and it excluded all patients in institutions.

It is important to realize that as the prevalence estimate is *reduced*, the seriousness of the need as measured by severity of impairment is *increased*. Corresponding to the increase in the seriousness of the psychiatric disorder is an increase in the need for expert diagnostic and treatment skills to service it. Thus, if we adopt the 10 per cent estimate of need, we adopt also the view that expert treatment and care resources should be available to meet this need, because all peripheral mental health problems have been excluded. This view was strongly reinforced by the opinions of psychiatrists, psychologists and social workers gathered during field interviews for this study.

Our Use of the Estimates of the Prevalence of Mental Illness

The foregoing discussion is relevant to the data derived from studies undertaken for this report in the following four ways:

- 1) The 20-25 per cent estimate of the prevalence of impairing psychopathology in Ontario's population derived from the Stirling County, Midtown and Heyfield studies can function as a bench mark for determining the extent to which treatment figures presented underestimate treatment need.
- 2) The 10 per cent estimate of potential demand will be used as the measure of the need for treatment by properly trained mental health professionals who are especially equipped by their training and experience to diagnose and/or treat psychopathology — psychiatrists, psychoanalysts, clinical psychologists, psychiatric social workers, and those in ancillary professions, such as psychiatric nurses and child care workers.
- 3) We assume that the existence of an actual and potential demand based on estimated need is in itself sufficient grounds for objecting to any artificial obstacles that may stand in the way of developing sufficient professional resources to serve it. It is also sufficient grounds for mobilizing resources to make mental health services of the highest possible quality available to approximately 700,000 persons (or 10 per cent of the province's population) at any given time.

¹⁴B. Pasamanick, D. W. Roberts, P. V. Lemkan and D. E. Drueger, "A Survey of Mental Diseases in an Urban Population", *American Journal of Public Health*, Vol. 48, No. 923, 1957.

- 4) The capacity to serve the needs of the estimated 20 per cent prevalence of psychogenic disability may be accepted as a reasonable long-term goal for mental health services development.

A general point should be emphasized here. There are important differences in the nature and severity of impairment of diverse mental illnesses. The same may be said of the extent to which treatment is mandatory, and the nature of circumstances of the treatment itself. In general, hospital and/or custodial treatment are mandatory for only the most dangerous illnesses. These occur in only about 2 per cent of the population. Consequently, when we suggest that there is a need for services competent to treat 10 per cent of the population, we do not mean that these should be hospital services, or that there should be an expansion of the government operated services. Rather, adequate professional and clinical resources of the appropriate kind should be brought into existence by public and/or private planning and action.

In conclusion, it should be re-emphasized that these estimates are in the nature of predictions of what would be found to be the case if studies, similar to those cited above, were conducted on the Ontario population. It is highly desirable that such studies with adequate depth and longitudinal dimensions be undertaken, because they provide the only basis for realistic planning.

Chapter 2 The OMSIP Data Study

Given the need for accurate prevalence figures for Ontario and because it was impossible to undertake a study of the Stirling, Midtown, Heyfield type, we decided to experiment with the diagnostic and treatment data collected by the Ontario Medical Services Insurance Plan. These offered three advantages; they contained a very large sample of the population; they contained diagnostic reports by a large sample of physicians of all kinds; and they contained information concerning consultations and treatments. The data are all derived from the subscribers' claim cards.

At first glance, the data collected through the administration of Ontario's medical insurance scheme appear to provide excellent information, regularly and automatically collected, for this and many other kinds of study. However, two principal defects need to be overcome: 1) physicians should improve the quality of their diagnostic reporting; 2) to current information should be added a report of the treatment method used and the employment of the patient. For the specific purposes of this study there is another shortcoming: OMSIP subscribers are not altogether typical of the Ontario population. Special provisions contained in the Plan for welfare and low income subscribers result in a proportionately greater number of individuals in these groups within the OMSIP subscriber population than in the general population. However, the division of subscribers into three categories — Low Income Subscribers (whose premiums are entirely publicly supported), Socially Assisted Subscribers (whose premiums are partially publicly supported) and Independent Subscribers (who pay their own premiums in full) — provides a useful socio-economic stratification of the population for the purposes of some specific comparisons.

Rationale of the Study

The OMSIP data were studied in the hope that the result might reflect the percentage of medically insured citizens who have become sufficiently impaired, or whose symptoms have been sufficiently distressing that they have sought the assistance of a physician, and whose disorder has been diagnosed subsequently as being psychiatric in nature. This figure would indicate two things: the number of persons who are in sufficient distress to seek the help of a doctor, and the extent to which physicians are now being confronted with mental illnesses in their practice.

Method of the Study

The period of May 1 to October 31, 1967 was selected. All claims of *certain* subscribers for that period were subjected to computer analysis, through the cooperation of the Health Data Centre of the Ontario Department of Health and with the help of their computer experts. In order to qualify as a member of the study population a subscriber had to be registered continuously through May 1 to October 31. Any subscriber who enrolled or terminated his enrolment during the period was not included. This criterion was used to ensure some measure of stability in the study population with respect to such properties as being a citizen enrolled in an insurance scheme with psychiatric benefits and being a member of a definable socio-economic group.

Sixty-three different types of physicians, including general practitioners, specialists and specialty combinations, were studied. Some special experiments were run on the data from patients of psychiatrists. The patient population of each *type* of physician was studied according to the diagnoses made. The diagnostic categories were non-psychiatric and psychiatric. Psychiatric diagnoses were further subdivided into psychosis, psychoneurosis, character and behaviour disorders, other psychiatric illnesses, alcoholism, psychiatric diseases of organic causes, and multi-service psychiatric claims. "Multi-service psychiatric claims" is a category for services known to be consultations or treatments for a psychiatric disorder but without a specific diagnosis. (This category is an artifact of a mechanical data storage problem. It could have been removed mathematically by redistributing the services and patients within this category according to reliable ratios determined within the framework of the study itself, but in most cases this would not have resulted in greater accuracy.) Thus the three basic parameters of the OMSIP study are the type of physician rendering service; the psychiatric illness being treated; and the socio-economic status of the patient receiving treatment.

It can be seen from the criteria by which the population of subscribers has been established that it does not represent the total number of subscribers for the period. Specifically, persons who enrolled during the period May 1 to October 31 have been excluded so as *not* to inflate artificially the numbers of individuals with psychiatric diagnoses; we have eliminated from the study population anyone who enrolled in OMSIP precisely because of a diagnosed psychiatric disorder for which he needed treatment.

Table 2.1 shows the most general result of the study. The data revealed that the prevalence of psychiatric disorder in the study population, as expressed in demand for medical services and diagnosed as such by a physician, is 4.7 per cent. The prevalence for the three socio-economic groups of the study are 5.3 per cent, 4.0 per cent and 5.1 per cent for socially assisted, low income and independent groups, respectively. These figures suggest that, although the manner of making

TABLE 2.1
OMSIP Subscribers Receiving a Psychiatric Diagnosis,
May 1–October 31, 1967

Socio-economic group	Population size in thousands	Numbers diagnosed as suffering from psychiatric disorder in thousands	Percentage of population so diagnosed
Socially assisted	316	17	5.3
Low income	543	22	4.0
Independent	312	16	5.1
Total	1,171	55	4.7

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967.

demands and the physician to whom the demand for psychiatric help is made may vary for the different socio-economic groups, the demand levels of the three groups are not significantly different.

The question arises as to the reliability of these figures. Do they establish, for example, that Ontario's population enjoys better mental health than the populations of Stirling County, Nova Scotia; Manhattan, New York; or Heyfield, Australia? Unfortunately they do not, although they are consistent with the most conservative estimates of the prevalence of mental illness which are based largely on hospital and clinical records. There are two separate questions to consider: 1) the intrinsic accuracy of the figures; and 2) their accuracy relative to the main problem at hand — namely, the estimation of the prevalence of mental illnesses that are sufficiently debilitating to cause individuals to seek medical help. The second question is dependent on the first.

Explanation of OMSIP Data Study Results

On the basis of the bench mark established in Chapter 1 of this report, the results of the study are conservative. Some explanation of this is in order.

When submitting claims to insurance plans, many physicians prefer to record their diagnosis symbolically: that is, in terms of a physical symptom of a psychiatric disorder, or in terms of a concomitant organic ailment, rather than as a standard psychiatric diagnosis. Thus, for example, backache may be the reported diagnosis, when the physician's real diagnostic opinion is that the patient's backache is associated with a psychoneurotic disturbance. Or chronic headache may be the reported diagnosis, when the physician's real opinion is that the individual has headaches because he is unable to deal adequately with certain personal relations.

Three factors reinforce this practice. One is the stigma that still attaches to mental illness. This stigma makes physicians reluctant to confront a patient

with the fact of a psychiatric diagnosis, or to make an official report of a psychiatric diagnosis — for example, on an OMSIP claim card. Such reluctance will arise especially on behalf of the 20 per cent of OMSIP subscribers whose physicians send them the claim card with the diagnosis on it, so that the patient can forward it to OMSIP for reimbursement. A second factor is the long-standing reluctance of insurance schemes to compensate for psychiatric services. Although OMSIP is exceptional in its coverage of psychiatric services as far as its formal provisions are concerned, there is probably a considerable carryover from past experience with other insurance schemes. The third cause is the reduced rate of reimbursement by OMSIP for psychiatric services rendered by non-psychiatric specialists. This factor would not influence the physicians who serve the 20 per cent of the subscribers who pay their physicians directly and then collect from OMSIP; but it would affect the physicians of the remaining 80 per cent. These physicians bill OMSIP directly and, in order to collect their complete fee, they would have to bill the patient for the remainder and explain the circumstance to him. Thus we are returned to the first factor — namely, the stigma attaching to mental illness.

There are four reasons for accepting this explanation:

- 1) Interviews with OMSIP officials confirmed it.
- 2) A check was built into the analysis of the data, the results of which strongly suggest the operation of the stigma factor. There is a social stigma associated with alcoholism which closely parallels the stigma against mental illness. As in the case of many mental illnesses, the physician has the option of reporting the illness in terms of one of its major physical effects (such as a liver ailment) rather than in terms of the immediate cause of the effect — alcoholism. That this substitution is practised widely by physicians in reporting a diagnosis of this condition is evident from Table 1.1, the significance of which has already been analyzed. This control within the study shows that the psychiatric data are conservative. Unfortunately, it cannot be used to measure *how* conservative the data are.
- 3) The open comments section of the questionnaires to general practitioners and specialists contained reports of resistance in patients to a psychiatric referral or to continuing in treatment with the physician once a psychiatric diagnosis was mentioned.
- 4) The diagnostic data contained in the questionnaires that were sent to general practitioners and specialists provide higher estimates of current demand for psychiatric services.

When the necessary corrections are made in order to compare the OMSIP data with data derived from the Mental Health Survey: Physicians, the following contrast can be stated: 7 per cent of the persons seen by general practitioners, general surgeons, orthopaedic surgeons, internists, neurologists, and obstetricians

and gynaecologists in Study 1 were given a psychiatric diagnosis, as opposed to 18 per cent of the persons seen by the same kinds of physicians in Study 3 (Mental Health Survey: Physicians). It would appear that the OMSIP data produce a highly conservative result for the reasons stated above. None of these factors, except the general taboo against mental illness, was operative in Study 3, because of its confidentiality vis-à-vis the doctor-patient relationship.

It is not possible, therefore, to use the OMSIP data to form a valid estimate of the prevalence of mental illness in Ontario. Nevertheless, one may perhaps legitimately use them as an estimate of the prevalence of very severe non-hospitalized mental illness, on the following assumptions: 1) the OMSIP data include those psychiatric illnesses in which the physician felt that he had no alternative but to report a true diagnosis; and 2) services to patients insured under OMSIP do not include any patients treated in Department of Health facilities. "Severe" here would involve both a great amount of debilitation, and the absence of "covering" physical symptoms or major concomitant organic problems. The only qualification on this interpretation would appear to be the existence of physicians who base their practice and the communications to the patients on realism. These physicians would find it necessary to state their professional opinion to their patients, even to those with mild pathologies arising out of emotional disorder; thus they would have no reason, except perhaps one of economic inconvenience, for misreporting a psychiatric diagnosis. It can be concluded, then, that the 46,718 psychoneuroses and 2,480 character and behaviour disorders reported were, for the most part, either severely debilitating or the only source of disability in the persons concerned; and probably they were both.

Let us see what projection of demand, as defined above, can be derived for the entire province by using the OMSIP data. The results of the OMSIP study suggest that socio-economic differences do not affect the demand of different socio-economic groups for medical services for psychiatric problems (see Table 2.1). Therefore, the percentage demand derived from the OMSIP study can be applied directly to the population of the province. This results in the estimate that 329,000 individuals who were very seriously impaired by a psychiatric disorder sought the advice of a medical practitioner and subsequently were diagnosed as suffering from a psychiatric illness.

Since our data apply to individuals who were seen and treated either in the office of a physician or in the psychiatric ward of a general hospital, they do not include patients that were treated in mental hospitals and other facilities operated by the Department of Health. These patients would have to be added to the total except in two circumstances: 1) when a physician has seen a patient and certified his referral to a mental hospital; 2) when a patient has returned from treatment in a mental hospital to a physician in private practice for follow-up consultations, supervision and treatment. Either circumstance would result in a double count. It has not been possible to determine with any accuracy the number of persons

in this category. The Mental Health Survey: Physicians provided an estimate of approximately one per cent referral to mental hospitals, by the respondents, of patients with psychiatric problems. Making the one per cent correction and adding the total number of patients recorded on the books of the institutions operated by the Ontario Department of Health, during the same period the total patient population (individuals receiving diagnostic, treatment and care services for a mental health problem) is approximately 380,000. This figure does not include persons treated by non-medical mental health professionals such as clinical psychologists. However, the number of persons so treated is insignificant; moreover, according to existing laws, a psychologist's patients or "clients" must be seen first by a physician and thus would be included already. It is obvious that our provincial estimate is crude, and subject to the qualifications applied to the OMSIP data. Nevertheless, when placed in perspective it is significant.

The provincial estimate cannot be used to measure the actual prevalence of mental illness in our population. The best we can do is derive projections based on studies done elsewhere. These studies suggest that planning of adequate mental health services should be based on the assumption that, at any given time, 20 per cent of the population will be in need of some form of mental health service. The figures based on the OMSIP data supplemented by Department of Health data make it clear that at least 5 per cent of Ontario's population have voluntarily sought these services. We can safely assume that this demand is generated by severe disturbance and impairment, for it amounts to only one-half of our estimate of potential demand (10 per cent of the population) for mental health services.

This conclusion gives cause for concern for two reasons. If, as has been argued, the individuals involved in these tentative projections are severely disturbed and impaired, they are in need of the attention of well-trained and experienced diagnosticians and therapists. But this is very far from being the case. Setting aside for the moment the 46,400 patients being treated in Department of Health facilities by Department of Health physicians, psychologists and social workers, and considering only the projected 329,000 being diagnosed and treated elsewhere, we find, on the basis of the OMSIP Diagnostic Data Analysis, that 12 per cent of the patients are being seen by psychiatrists; 78 per cent are being seen by general practitioners; and the remaining 10 per cent are being attended by other specialists, none of whom (with the possible exception of neurologists) has received any formal training in the diagnosis and treatment of mental illness. This problem will be examined in greater detail in a later chapter; but, *prima facie*, it is reason for considerable concern.

The second consideration is this. Existing hospital, residential treatment, clinical and private practice facilities in the province are heavily burdened; and in most cases they are overburdened, even in relation to the scope of services now being offered. Evidence of this fact is the existence of mental hospitals that are still unable to progress beyond custodial care to well-designed and executed treat-

ment and rehabilitation programs. This state of affairs is itself the product of the chronic and widespread inadequate supply of professional resources in all services. When one looks beyond the Ontario Hospital, the general hospital, and the clinical services to other needed services — such as treatment centres for youthful and adult offenders, treatment services in the schools, and perhaps most important of all, private individual and group practices — the picture becomes increasingly bleak.

If the situation is unsatisfactory now, it is certain to get worse unless remedies are found. Mental health services have been improved steadily since the Second World War. But as mental health services improve in quality and quantity they produce an increase in the demand for them, because more people with mental health problems are encouraged to seek help. The individual who formerly would not admit his disorder when the only place for treating “insanity” was the “nut-house” in the next county — an institution scarcely distinguishable from the jail in his own — now might be prepared to seek help at a community clinic, where he can talk privately to a skilled mental health professional. Also more professional persons who act as advisors to other individuals — such as teachers, clergymen, probation officers, judges, lawyers and physicians — are becoming increasingly sophisticated about mental health problems in their pupils, clients and patients. Instead of acting out neurotic processes with them on the one hand, or rejecting the individual with his neuroticism on the other, they tend to interpret the disturbed behaviour, beliefs or attitudes as a symptom of a psychological disorder and advise the individual to seek appropriate help. This general improvement in the level of psychological insight among professional and semi-professional people of all kinds is inevitable and highly desirable. A number of private and public groups, such as the Ontario Mental Health Association, the Ontario Association for Children with Learning Disabilities, the Ontario Association for the Mentally Retarded, and local groups such as the Toronto Psychoanalytic Forum of the Humanities promote a better understanding of mental health problems and the determination to find remedies for them.

Thus, the manpower problem may reach crisis proportions within the next decade as demand for service doubles simply as a result of the efforts now being made to serve existing levels of demand. This escalation effect can be demonstrated in many different settings. The experience of Service Three, New Haven, Connecticut and the British Health Ministry have already been cited (pp. 13-14). The same effect is to be found in Ontario's expanding outpatient services. It is evident also in private practice. Until recently at least, there were six times as many psychoanalysts in private practice in Montreal as there were in Toronto. Nevertheless, the demand for their services was, if anything, greater than the demand for the services of the much smaller number of psychoanalysts in Toronto. If this view is correct, it presents a strong argument not only for doing more

of what is now being done, but also for providing solid support for experiments in the training of more and perhaps different personnel and in the development of new services to be manned by them.

The fact is that no one knows exactly what is the extent of unserved mental health need in the province's population. The epidemiological literature establishes that the 20 per cent figure is probably realistic. Every new additional service is a probe in the direction of discovering the limit of the need. That Ontario's existing services are a long way from finding those limits is evidenced by the speed with which any new service is swamped. Exactly how far we have still to go cannot be measured on the basis of any data accumulated by this study, but it is clear that there is no danger of overshooting the mark. And even if there were such a danger, a strong case for vigorous expansion could be made, because only when immediate demand for service is adequately met can professions that are rightly and necessarily service-oriented devote the time and energy to research and teaching that also is needed.

Conclusions

There is a need for a scientific study of the prevalence of mental illness in demographically variegated populations of Ontario in order to provide more adequate guidelines for the planning of mental health resources than now exist. These studies should be integrated with pilot projects for the provision of comprehensive psychological and social services, which will be discussed at a later stage.

The OMSIP claims file is an invaluable source of data. Recognizing its potential, the Department of Health has created the Health Data Centre to perform a wide range of useful data processing tasks in connection with health studies. The OMSIP claims file will improve as such when OMSIP's coverage becomes universal. As a collection and storage instrument for scientific data, however, it has a number of defects that need correction and improvement. The data are as accurate as the physician's diagnostic skill and the accuracy of his reports. As far as mental health data are concerned, the causes of error have been discussed already. One might add that doctors are among the rugged individualists of our society, and they are not inclined to be especially cooperative or careful in performing routines which they consider to be bureaucratically fussy, if not socialistic, and which they suspect as being potential invasions of their privacy. However, one suspects that physicians may also be somewhat lacking in standards of scientific exactness. It would be useful if they could be persuaded to think of every diagnosis as a scientific investigation, and every report of a result as a report of a scientific finding. If such an attitude were to develop towards OMSIP reporting, the OMSIP claims file could become a very useful scientific instrument.

In addition to the report of a diagnosis, the following information would be useful: a classification of the nature of the service, whether diagnostic or thera-

peutic (consultations to adjust a treatment being considered as a therapeutic service); information as to what the result of a diagnostic investigation is (for example, "no treatment indicated"; "referral for treatment by another physician"); nature of the treatment given by the physician himself; the employment of the patient. This additional information would make the data stored in the claims file useful for checking such things as the efficacy of treatment procedures, the role of social environment, work, and other factors in the causation of illness and, thus, would greatly enhance its scientific usefulness.

However, a moral problem arises at this point. What happens to the privacy of the relationship between patient and physician if this information becomes available for research purposes? The problem must be faced, but it is by no means an insuperable obstacle. Researchers, like physicians, have a code of ethics which requires them to respect the privacy of personal information, among which is information about a patient's health. Adherence to this code of ethics by researchers can be guaranteed administratively by the Health Data Centre itself simply by providing numerical data about groups of individuals and never about individuals. In this way the anonymity of individuals is absolutely assured. Ours was the first research study to avail itself of the data resources contained in the OMSIP claims file, and we can report that the principles just stated were operating principles of this research and are operating principles of the Health Data Centre for all research with which it cooperates.

The analysis of the data in the literature and accumulated by this study suggests that there is an urgent need to at least double Ontario's mental health resources. But before accepting this conclusion, it is necessary to consider a counter-argument. Let us assume that the explanation for the apparently conservative nature of the OMSIP data is correct. It would follow that many more persons with mental health problems are being seen by physicians and treated by them

TABLE 2.2

Percentage of Psychiatric Diagnoses by Physicians in Studies 1 and 3 Compared

Type of physician	Psychiatric diagnosis as a percentage of all diagnosis	
	OMSIP Study	Medical Study
General practitioners	7.8	18.1
General surgeons	2.6	12.4
Internists	5.4	25.1
Neurologists	14.7	35.5
Obstetricians and gynaecologists	2.6	15.3

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians; *OMSIP Diagnostic Data Analysis (Study 1)*, 1967.

than appears from the OMSIP data. As Table 2.2. shows, general practitioners and some specialists, especially internists and neurologists, see and treat many more psychiatric disorders than are reported on OMSIP claim cards.

The discrepancies are quite striking, even assuming that the percentages derived from Study 3 are deflected upward by the fact that physicians who take an active interest in the mental health problems of their patients would be more inclined generally to respond to a questionnaire dealing with this subject than those who take little or no interest. (The number of respondents was not large enough to safeguard against the effects of this tendency.) However, it is unlikely that such a factor explains the discrepancy. A study of psychiatric diagnoses reported on the questionnaires showed the variance to be extreme. In addition, physicians who diagnosed scarcely any psychiatric illnesses were reasonably well represented among the respondents; although this fact does not rule out the possibility that there are proportionately more physicians in the total doctor population who diagnose scarcely any psychiatric disorders than in the Study 3 sample. Thus it appears that considerably more patients with mental health problems are seen by Ontario's physicians than the OMSIP data would suggest.

But identifying a mental health problem is one thing, and treating it successfully is quite another. Relatively few of the respondents to the questionnaires expressed full satisfaction with the treatment programs they were able to institute for their patients with mental health problems, either themselves or by referral. Of the respondents who made comments only twenty-nine expressed a desire for an increased utilization of general practitioners in dealing with mental health problems, as compared with thirty-two who mentioned the need for more psychologists and social workers; 115 for more outpatient clinics (which involve paramedical personnel); and 157 for more psychiatrists. The vast majority of the comments in the questionnaire expressed high levels of dissatisfaction with the therapeutic programs that the physicians themselves were able to inaugurate under the working conditions of a demanding practice and a training directed towards solving strictly physical medical problems. Furthermore, it is reasonable to raise a question concerning the quality of psychiatric treatment that most physicians are able to provide. Even the higher figures of Study 3 contain a very large number of persons suffering considerable disability from psychoneurotic problems. It is doubtful that a rather superficial investigation of the patient's life situation, the interpretation of apparently physical symptoms as being psychogenetic, encouragement, practical advice and drugs (which is about all that most physicians have time or training to provide) can do more than, at best, serve as a temporary palliative for the symptoms.

These points are not intended as criticisms of the medical profession, but as a basis for rejecting any idea that minor improvements in the existing scale and organization of resources are all that is needed. We will be in a better position to discuss this question at a later point, but it is obvious that the vast majority of

Ontario's physicians (psychiatrists excluded) are not mental health experts. Clearly, many doctors recognize this state of affairs and are dissatisfied with it. Nevertheless, as we found in Study 3, currently physicians themselves are not only saddled with the responsibility of identifying mental health problems in their patients, but they must also diagnose and treat them. The most important group of physicians in this context are the general practitioners. Study 3 shows that the general practitioners in the sample, on the average, treat 88 per cent of the psychiatric disorders that they diagnose.

We begin our study of mental health professions from the premise that Ontario needs to have at least double its present mental health resources in order to begin to cope adequately with existing needs. In and by itself, this premise is not meaningful until the nature of these needs and resources is more precisely delineated. In the following chapters we will discuss them in the context of the examination of the various mental health professions and services.

Part Two: The Mental Health Professions

Chapter 3 Some General Considerations

The mental health field contains a major division between the medical and the psychological professions. This division has several different aspects: scientific, technological, training and educational, service, legal, economic, social, linguistic, and even psychological. One would have thought that the mental health professions, made up as they are of individuals who are especially skilled in the resolution of psychological conflicts, would have long since brought these skills to bear on their own professional interactions so as to bring about a condition of harmonious cooperation among the groups involved. One finds, however, that professional rivalry and medical authoritarianism are cited frequently in explanation of the absence of sufficient numbers of psychologists and social workers. Competition is no doubt desirable, and in any case cannot be eliminated from human interaction; but it should improve, not endanger or diminish, the quality of service rendered by professions to the public. The achievement of socially useful competition and cooperation among the mental health professions, in the context of the real differences among them, is a precondition for the full utilization of existing science and technology in the service of mental health needs in the province's population.

At present medicine dominates the mental health field. Current legislation permits a general practitioner without benefit of training or formal qualification to perform the services for which a clinical psychologist is trained, while the clinical psychologist may treat a psychoneurotic person by means of a psychological therapy only upon referral from a physician.

The dominance is also social. In any service where there is a physician and other professional personnel, usually the physician acts as director of the service and is deferred to in decision-making by members of other professions. The settings in which psychologists or social workers perform this leadership or management function are, for the most part, settings in which there are no physicians working except on a consultative basis.

Finally, medicine as a profession is numerically dominant in mental health,

there being more physicians than any other professional group in the field. These facts underscore the importance of a clear scientific principle for differentiating the roles and services of medicine, psychology, social work, nursing, education and general care in the mental health field. In this connection, the development of psychoanalysis in Canada is particularly instructive, and it will be used as a model from which to construct a guide for future development. But there are also philosophical and scientific divisions within the mental health professions themselves to which we must now turn our attention.

Some Theoretical Conflicts

The Physicalist vs. the Psychodynamic Hypothesis

At the extreme end of the spectrum there are psychiatrists and psychologists who postulate a *direct* organic determination of any symptom of any mental illness. This hypothesis has far-reaching implications for therapy and, hence, for understanding the development of psychiatry and the role of medicine in it. If every psychiatric symptom has a direct organic cause and if this cause itself is not subject to alteration except by a physical force (either mechanical or chemical) impinging upon it, then the only useful psychiatric therapy will be either physiological or pharmacological. In keeping with this hypothesis, the task of psychiatry is to discover and apply physiological, surgical and drug therapies. At the present time, there are a number of techniques of this type available: electroconvulsive therapy, insulin shock therapy, prefrontal lobotomy, and the psychotropic drugs. Each of these procedures, with respect to both the mechanics of its application and the nature of its direct and indirect effects on the patient, is such that it must be applied and supervised throughout by a physician.

If, therefore, techniques of this type are to be unique instruments of therapy for mental illnesses, three corollaries follow: diagnostic and therapeutic procedures should be the responsibility of medical specialists; the relationship of the physician to the patient in psychiatry is as extrinsic to the treatment itself as it is in the practice of surgery or internal medicine; the contributions of mental health professionals other than psychiatry are *essentially* of an auxiliary nature. The clinical psychologist may assist with diagnosis and the rehabilitation of the patient; the nurse may care for his needs in hospital; the social worker may maintain liaison between the hospital and the patient's family and assist in the social rehabilitation of the patient when needed. But these services are primarily adjuncts to the therapy rather than a part of it.

It also follows from this hypothesis that psychiatry has at last gained the status of, and acceptance as, a major specialty within medicine, as a direct result of the discovery of these physiological and chemical therapies. These discoveries have enabled psychiatrists to become more than alienists providing custodial supervision for the insane. This position, or modified versions of it, has advocates among

Ontario's psychiatrists, especially among general psychiatrists who are in full-time hospital practice. However, it is far from being universally accepted.

The position in psychiatry has some inherent limitations. The list of physiological therapies available is less impressive than it appears, because psychosurgery and insulin shock therapy have been largely abandoned. Prefrontal lobotomy is no longer used by the vast majority of psychiatrists except in the most unusual circumstances and when all other treatment methods have been tried and have failed. Senior psychiatrists at New York's Bellevue Hospital, where pioneer work in insulin shock therapy was undertaken, report that its use has been discontinued because it has not proven efficacious. Information gathered by interviews and questionnaire (Mental Health Survey: Psychiatrists) indicates the same development in Ontario. Thus electroconvulsive therapy and psychotropic drugs are left as the major instruments of specifically medical treatment for mental illnesses. There are a few psychiatrists who would not prescribe electroconvulsive therapy because they fear that it may do psychological damage to the personality of the patient, or it may produce brain damage. However, it is in very wide use by psychiatrists for the treatment of depression associated with psychosis or severe neurosis.

Table 3.1 associates and compares the number of psychiatrists, their ages and locations of training with respect to the frequency with which they use insulin shock, surgery and individual psychotherapy for the treatment of mental illness. The relative infrequency of the use of insulin shock and surgery as compared with individual psychotherapy is obvious.

Many psychiatrists feel that their work should not be restricted to the use of physical or chemical therapies, but should include, as well, the psychological

TABLE 3.1
Comparison of the Use of Insulin Shock and Surgery with Psychotherapy
by Ontario Psychiatrists
(for one-week period)

No. of psychiatrists	Age				Where Trained		Treatment method	No. of patients
	30 or under	31-45	46-60	61 or over	Ontario only	Ont. and/or else where		
4		2	2		4	0	Insulin shock	10
5		4	1		5	0	Surgery	12
							Individual psychotherapy	
116	11	78	24	3	60	47		1,461

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

therapies that have been developed since Freud's discovery of psychoanalysis at the turn of the century. Among these are psychotherapy (both individual and group), supportive counselling, and the supervision of milieu therapy;¹ psychoanalysis itself is excluded, because psychiatrists are not qualified in its techniques.

Finally, the physicalist hypothesis has a philosophical implication concerning the being of man as well as a psychological implication which gives rise to skepticism about its claims. J. S. Mill has stated the position of philosophical materialism concerning the causation of mental life in man as follows: any mental event or activity will have an organic and a mental antecedent, each of which will contribute to the determination of the event or activity in question and in consequence be *necessary* to its production; but one or other of the organic or mental antecedents may function as the *sufficient* cause. This causal hypothesis is implicit in Leighton's differentiation, cited earlier,² between psychiatric disorders in terms of their predominant etiological determinant. It shares with the physicalist hypothesis the assumption that the production of any mental activity depends on the activity of a physical organ. It denies, however, the truth of the conjunction that forms the antecedent of the physicalist hypothesis by denying that organic causes are the *only* sufficient causes of specific psychological phenomena, such as perceiving, thinking, feeling, whether healthy or unhealthy. It postulates, instead, the psychogenesis of at least some of these phenomena.

Correspondingly, the physicalist hypothesis implies not only that human interactions are ancillary to psychiatric therapy but, more generally, that they are of secondary importance in the determination of personality formation and functioning. On the other hand, many psychiatrists believe that human interactions (especially parent-child relationships) play a crucial determining role in conjunction with psychophysiological processes in personality development. In particular, the nature and severity of psychoneurotic symptoms are thought to derive from just these personal interactions. If this assumption is correct, it may be that the only possible remedy for illnesses deriving from these causes is one that utilizes the instrumentality of human interactions. And, although it remains in principle possible to treat the physiological effects of the psychological experiences that cause psychoneurotic symptom formation, psychiatry is still far from being able to do this satisfactorily. The possibility of such an achievement is sufficient to justify investment in research. But it does not provide a convincing argument against the full utilization and development of psychological therapies to reduce the suffering of those who will respond to such treatment.

The hypothesis of the psychogenesis of certain mental illnesses which are not

¹This list is much simplified. Thirty-six different psychological therapies have been identified and described. Cf. R. A. Harper, *Psychoanalysis and Psychotherapy*, Prentice-Hall, Englewood Cliffs, 1959. However, it enumerates the major categories into which the psychological work of Ontario's psychiatrists, psychologists, social workers and physicians falls.

²See p. 6 of this report.

genetically inherited, the result of injury to the brain, or psychotic, and which fall within the symptom patterns of psychoneurosis and character and behaviour disorders, has a number of implications that differ significantly from those of the physicalist hypothesis. The traditional content of the medical curriculum does not equip the medical practitioner per se with the specific diagnostic and therapeutic skills needed for the detection and treatment of psychogenetic mental illness. But clinical psychologists and psychiatric social workers could be equipped by their training, *in principle at least*, to diagnose and treat these disorders by means of psychotherapy and supportive counselling.

The diagnostic and therapeutic contributions of clinical psychologists and psychiatric social workers, *assuming appropriate training*, are not merely auxiliary to psychiatry but are as important as those of the psychiatrist who is a trained psychotherapist. And they are of greater worth than those of the psychiatrist who is not a trained psychotherapist in that part of the mental health field that involves the use of psychological therapies to treat non-psychotic and non-organic psychological disorders.

Finally, although psychoanalysis and psychotherapy are medical specialties, with one very important qualification to be discussed later they may be validly developed by clinical psychologists, psychiatric social workers and others.

From a strictly scientific point of view, psychoanalysis and psychotherapy are interprofessional specialties, with the proviso that the medical profession is essential to each. In this sense, medicine has a prior but not a unique claim to them. In the treatment of mental disorders a course must be chosen between overlooking psychological determinants in favour of organic causes, and overlooking organic determinants in favour of psychological causes. Physicians trained in psychodynamics are the only professionals who are equipped specifically by their training to chart this course. However, once a physician has established that psychological, rather than physiological or pharmacological, therapy is indicated, the subsequent diagnosis and treatment can be conducted by a suitably trained non-medical specialist.

Two qualifications must be introduced at this point. First, psychiatrists and psychologists alike, in a variety of settings in Canada and the United States, testified that the clinical psychologist using his battery of tests is better able to detect brain damage and specify its nature than can the physician in a typical office consultation or by using the test devices available to him. A clinical psychologist in a large general hospital in Toronto with a busy psychiatric inpatient and outpatient service reported that the difficult cases with an uncertain diagnosis are referred to him routinely for assessment, although *legally* he is not permitted to make the diagnosis. A senior psychiatrist at the Clarke Institute commented that the electroencephalograph, which records the levels and patterns of electrical discharge from the brain, cannot equal the diagnostic refinement of the clinical

psychologist's test instruments in locating brain damage. Our field work presented a great deal of evidence that *in practice* clinical psychologists contribute far more to the use of suitable techniques than one would expect, given the official medical view.

Second, several psychiatrists interviewed commented that medical education and training are a liability rather than an asset in diagnosing and treating the vast majority of mental health problems, because they teach the therapist to overlook the psychogenetic factors in favour of a search for hypothetical organic factors.

The members of the mental health professions who base their work on the psychodynamic hypothesis trace the expansion of the role of the psychiatrist beyond that of the alienist to the development of both the new physiological and pharmacological methods of treatment, and the psychological therapies that have grown out of psychoanalysis.

This general position appears to be the working premise of a majority of the members of Ontario's mental health professions. It is reflected, for example, in the emphasis placed on psychotherapy in the Brief to the Committee on the Healing Arts by the Ontario Psychiatric Association. Table 3.2 shows that psychotherapy is the preponderant form of treatment, even though electroconvulsive therapy (ECT) and drugs, singly or in combination, are much easier and faster to administer. The comparison is not unambiguous, however, and can be easily misinterpreted. It must be understood that these distinct physical and psychological therapies are appropriate to different illnesses and that the disorders for which psychotherapy is appropriate are relatively much more common than the disorders for which ECT and psychotropic drugs, in particular, are generally used. Nevertheless, most of Ontario's psychiatrists evidently now base their practice on what has been called the psychodynamic hypothesis. This intermediate position is the one that the author has found most convincing.

Faith Healing

The third and final position has no scientific basis, nor has it any adherents among the members of the mental health professions. It is restricted, by and large, to individuals and groups who without adequate training or, in some cases, without *any* training preparation, undertake to render quasi-physiological and quasi-psychotherapeutic "cures" for the symptoms of psychiatric disorders. These persons — faith healers, naturopaths and psychiatric quacks — act on a belief in the dominance of psychic over all other types of causality. They tend, in consequence, to discount or even repudiate the contribution of medicine to the diagnosis of illnesses, including mental illness. These individuals and groups work without an adequate relation to a qualified medical practitioner and without an adequate understanding of the nature and effect of their own "therapeutic" interventions, to the detriment of their client's purse and with the risk of a serious aggravation of his health problems.

TABLE 3.2
Psychological and Physiological Therapies by Ontario Psychiatrists
(for one-week period)

Utilization	Type of treatment									
	Psychological					Physiological				
	Individual psychotherapy		Group psychotherapy		Individual counselling		Group counselling		ECT	
	No.	%	No.	%	No.	%	No.	%	No.	%
Number of psychiatrists using treatments	116	78	51	34	47	31	9	6	48	32
Number of patients in treatment	1,461		502		250		62		184	
									855	
									38	25
									178	

SOURCE: C. Hanly and W. Christian, Mental Health Survey: Psychiatrists (Study 2), 1967. Based on a questionnaire survey of Ontario psychiatrists.

Undesired Effects of Theoretical Conflicts

These axiomatic differences cut across professional boundaries and generate not only useful competition, advantageous to scientific research and therapeutic service, but also unfortunately, counterproductive conflicts. We were surprised to discover adherents of the physiological school of thought (psychiatrists and psychologists) confusing the work of their colleagues of the psychodynamic school with the quackery and magic of faith healers. For example, psychoanalysis is viewed by them as "rot", "a first-class form of modern quackery" and as having "filled the same vacuum in mental disorders as the witchdoctors in Africa did for physical ailments". This attitude is not reciprocated by psychoanalysts or psychodynamically oriented psychiatrists, psychologists and social workers. Their position is not that organic determinants are irrelevant to mental illness or that drug and physiological therapies are inappropriate per se, but that physiological and drug therapies are indicated for illnesses in which organic determinants predominate, and that psychotherapy or psychoanalysis is indicated for illnesses in which psychological determinants predominate.

The existence of this conflict, particularly in psychiatry and psychology, is not in the best interests of the development of the varied mental health resources needed to serve Ontario's population.³ The traditional dominance of the physiological, narrowly medical approach has delayed the introduction of psychodynamic theory and supervised psychotherapeutic practice into the psychiatry curriculum of Ontario's medical schools. Numerous psychiatrists interviewed who had trained in Ontario prior to the quite recent introduction of supervised psychotherapy found that their formal training had scarcely prepared them at all for the demands of their practice, which consisted largely of treating psychoneurotic patients by means of psychotherapy. As Tables 3.3 and 3.4 indicate, there is widespread dissatisfaction with the adequacy of training in Ontario in psychotherapy.

The notable point is the variation in the rating of training in general psychiatry as compared to psychotherapy in Ontario's schools of psychiatry. Eighty-three psychiatrists, or 56 per cent of the respondents, rated training in general psychiatry good; only 16 per cent of the respondents rated training in psychotherapy good, 45 per cent rated it fair, and 30 per cent rated it poor. Eleven respondents in the sample under thirty years of age, who may be assumed to have benefited from recent improvements in the psychodynamic and psychotherapeutic content of the curriculum, still find psychotherapy lagging behind general psychiatry in quality.

This flaw in training has accounted in part for the loss of promising young psychiatrists to the United States, as recent research has confirmed. W. E. Powles

³For a full discussion of the theoretical issues involved in the development of psychiatric curricula, see A. Lewis, "Empirical or Rational? The Nature and Basis of Psychiatry", *The Lancet*, July 1967. See also R. A. Cleghorn, "Two Cultures in Psychiatry", *The Canadian Medical Association Journal*, July 1965.

TABLE 3.3**Evaluation of Training in General Psychiatry in Ontario by Ontario Psychiatrists**

Age of psychiatrist	Rating of general psychiatry training				
	Excellent	Good	Fair	Poor	No opinion
30 or under	1	6	2	2	0
31-45	3	57	23	8	4
46-60	8	17	5	1	2
61 or over	1	3	2	1	1
	—	—	—	—	—
Total ¹	13	83	32	12	7

¹These horizontal totals equal 147 and 145 respectively, because in a few questionnaires this section was left blank.

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

TABLE 3.4**Evaluation of Training in Psychotherapy in Ontario by Ontario Psychiatrists**

Age of psychiatrist	Rating of psychotherapy training of psychiatrists				
	Excellent	Good	Fair	Poor	No opinion
30 or under	0	1	8	2	0
31 - 45	1	14	41	34	4
46 - 60	2	8	12	6	4
61 or over	0	1	4	2	1
	—	—	—	—	—
Total ¹	3	24	65	44	9

¹These horizontal totals equal 147 and 145 respectively, because in a few questionnaires this section was left blank.

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

has shown that physicians seeking specialty training in psychiatry have gone to the United States for training because they cannot get training in Canada in areas such as child psychiatry and psychodynamics, including psychoanalysis and psychotherapy. He sent questionnaires to 542 psychiatrists in the United States believed to be from Canada. Three hundred and eighty-seven were returned. Of these, 293 were from Canadians, 237 of whom had received most of their postgraduate training in the United States. Almost 50 per cent of them were under forty-three years of age. Powles estimates that there are 293 to 760 ex-Canadians practising in the States who received their medical training in Canada (but not for the most part their psychiatric training). This number represents from

one quarter to two-thirds of the membership of the Canadian Psychiatric Association.⁴ Given the severity of Ontario's manpower difficulties, this loss of young highly qualified practitioners is most serious.

There is another crucially important feature of the difference between the *exclusively* physiological and the psychodynamic approach to mental illness. As one leading Canadian psychiatrist put it, "The first patient the medical student sees is a cadaver in the anatomy lab." Medicine necessarily is strongly, although by no means exclusively, physiologically oriented. The product of training, however, may prevent the non-psychiatric physician from contributing effectively to the identification and treatment of mental health problems in his patients.

R. G. Stennett has commented recently on this problem in connection with the treatment of school children who are not progressing at school because of emotional handicaps.⁵ Such a child may be taken to the family physician and found to be in sound physical health. The attitude of the physician is quite appropriate, in that his function is to assess the child's physical health. But because of the generalized authority assigned to physicians concerning health matters of all kinds, parents can easily assume, with or without any such suggestion from the physician, that the psychological problem will resolve itself automatically and need not be treated at all. Evidence suggests that this implicit hope for spontaneous restoration is not very realistic in most cases. The public attitude that assigns to the physician, *per se*, the role of a final authority in all health matters acts as a deterrent on recourse to other medical and non-medical sources of help. The infallibility of the physician may be a useful myth, because it can act as a defence against painful anxiety and maintain confidence in the face of risk. But it also has disadvantages such as those pointed out by Stennett. These are multiplied whenever the physician himself is tempted to incorporate his mythical social identity into his practice.

Finally, from the vantage point of this analysis, one can expand on a critical comment on Ontario's psychiatric services made by McKerracher.⁶ McKerracher says that Ontario has the oldest and most firmly established traditions in psychiatry. This he sees as both an advantage and a disadvantage: an advantage in terms of the magnitude and quality of existing services; but a disadvantage because the inertia of this tradition acts as a deterrent against experimentation and acceptance of improvements generated by experimentation elsewhere. This inertia is not a formless force. It is composed of a rather rigid adherence to a narrow medical,

⁴Address to the Ontario Psychiatric Association, W. E. Powles, M.D., Toronto, February 1, 1969.

⁵From the *Globe and Mail*, Toronto, February 8, 1968. Report on an article by Dr. R. G. Stennett (University of Western Ontario, also Research Director for the London, Ontario Board of Education) published in a "recent" issue of *Canada's Mental Health*.

⁶D. G. McKerracher, *Trends in Psychiatric Care*, Queen's Printer, Ottawa, 1964, pp. 77-89.

custodial, management concept of psychiatry in the province's mental hospitals, and it has had four effects:

- 1) It has placed physicians in authority over, rather than in cooperation with, other mental health professionals, especially psychologists.
- 2) It has unnecessarily restricted the contributions of other professions.
- 3) These two factors have made it difficult for psychiatric services in the province to attract and retain first-class clinical psychologists.
- 4) The three above factors combined have diminished the worth of the mental hospitals as training settings for psychiatrists.

It would be misleading to suggest that this description presents an accurate picture of all of Ontario's mental hospitals. But it still applies to some in varying degrees, and judging from the comments of the younger psychiatrists who were trained in the Ontario Hospitals before the recent modernization of the curriculum, it has been the dominant state of affairs in the past.

Conclusions

In summary, certain of the divergences of viewpoint and practice among and within the professions in the mental health field derive from axiomatic differences which must be understood in order to understand the harmony and conflict, cooperation and obstruction, that exists in the working relations of individuals and groups within the field. Further descriptions of the theoretical views and their bearing upon principles of training, licensing and regulation will be taken up in the detailed studies of each of the professions. There, too, we will discuss the social and economic forces at work, as well as legal and institutional factors.

Chapter 4 Psychiatry

According to the lists of the Ontario College of Physicians and Surgeons, there were 367 certified psychiatrists in Ontario in 1967. The Ontario Medical Association, as of June 1967, listed 484 physicians on their psychiatry list. This list includes residents in psychiatry, specialists other than psychiatrists, and general practitioners who have a special interest in psychiatry.

General Characteristics of the Practice of Psychiatry

A questionnaire survey of Ontario's psychiatrists was conducted using the Ontario Medical Association list. The following data are based on the responses of 149 psychiatrists.

Age and Sex Characteristics

Table 4.1 shows the distribution of psychiatrists in Ontario by age and sex. The increase in the numbers in the age group 31-45 over the age group 46-60 is most encouraging. But if the sample in the under 30 group reflects the true situation, the encouraging trend is in the process of reversing itself. In fact, there are unoccupied places for residents in psychiatry in teaching hospitals. A survey of a premedical year at the University of Toronto showed that thirty-seven of 130 students were seriously considering a career in psychiatry. But these students will have to run the gauntlet of the traditional clinical disciplines. In the past, the attrition rate has been high. It will be argued subsequently that improvement in the amount and quality of psychiatric content in the undergraduate curriculum in medicine is the best method for correcting this situation.

TABLE 4.1
Distribution of Psychiatrists According to Age and Sex

		Age groups								Total number ¹
		30 or under		31-45		46-60		61 or over		
		No.	%	No.	%	No.	%	No.	%	
Number of psychiatrists	Male	11	8	88	66	30	22	5	4	134
	Female	—	—	7	54	3	23	3	23	13
Total		11	8	95	65	33	22	8	5	147

¹Two respondents did not fill out this portion of the questionnaire.
SOURCE: C. Hanly and W. Christian, Mental Health Survey: Psychiatrists (Study 2), 1967.
Based on a questionnaire survey of Ontario psychiatrists.

Post-certification Subspecialty Training

Thirty-five of the psychiatrists in the sample reported having undertaken additional training and/or study in a number of different areas subsequent to certification. These broke down as follows: clinical psychiatry, two; hospital psychiatry, seven; forensic psychiatry, three; child and adolescent psychiatry, eight; psychoanalysis, five; research techniques, two; ward administration, two; psychotherapy, three; community psychiatry, three.

Hours of Practice

Hours of practice varied considerably, ranging from part time to a Herculean work week in excess of sixty hours. As Table 4.2 shows, most psychiatrists work fifty hours or more per week.

TABLE 4.2
Hours of Practice, Ontario Psychiatrists

Number of psychiatrists	Hours worked per week						Total
	0-9	10-19	20-29	30-39	40-49	50+	
	0	3	2	7	49	75	
							136

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

The conditions of psychiatric practice for most psychiatrists are such that relatively little time is available for ongoing study leading to the incorporation of new ideas and the mastery of new skills, let alone for making contributions to the scientific literature on theory and therapy. Yet the highest quality services usually are associated only with practice conditions that provide ample opportunities for research. At the present time, the pressure on therapeutic services of all kinds is so great that a conflict of priorities almost inevitably arises for psychiatrists with a research interest. This pressure results in additional functional competition for psychiatric skills. Awareness of the problem among psychiatrists is clear from the Ontario Psychiatric Association Brief to the Committee on the Healing Arts. Having emphasized the importance of research into emotional and developmental problems in children, transformations in family structure and roles, delinquency, addiction and psychosis, this brief concludes “that there is a terrific need . . . for personnel who are not only interested in research but have had a suitable training in this special discipline”.

Practice Preferences

An attempt was made to measure the impact of the demands of the Ontario system of dispensing mental health services upon psychiatrists by asking them to what work in psychiatry they would like to be able to devote more time than the demands of their practice presently allowed.

This section of the questionnaire did not enumerate research as one of the possibilities; however, an open category was included with a request to specify. Fourteen respondents noted research as their preference. Altogether six other responses were made, all of which fell into the general area of service, including: planning mental health resources, preventive psychiatry, liaison, cross-cultural psychiatry, alcoholism and milieu therapy. Responses to the enumerated categories are presented in Table 4.3.

TABLE 4.3
Practice Preferences of Ontario Psychiatrists by Subspecialty

Nature of work	Positive responses		Negative responses		No responses	
	No.	%	No.	%	No.	%
Education and training	63	42.3	37	24.8	49	32.9
Community psychiatry	40	26.8	48	32.2	61	40.9
Family psychiatry	40	26.8	49	32.9	60	40.3
Adolescent psychiatry	33	22.1	52	34.9	85	57.1
General psychiatry	30	20.1	65	43.6	54	36.2
Forensic psychiatry	24	16.1	68	45.6	61	40.9
Psychoanalysis	15	10.1	67	45.0	67	45.0
Child psychiatry	15	10.1	68	45.6	66	44.3
Public health	10	6.7	69	46.3	70	47.0
Industrial psychiatry	6	4.0	73	49.0	70	47.0
Mental retardation	4	2.7	73	49.0	72	48.3

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

Positive responses indicate the number of respondents who would like to be able to devote more time to the area of psychiatry in question than the demands of their practice permit. Negative responses and no responses indicate the number of psychiatrists in the survey who are satisfied with the degree of involvement, which could be anything from 0 to 100 per cent of their work week, in the service or area of psychiatry in question. The positive responses are not additive, since many respondents indicated a preference for more than one of the areas while others indicated complete satisfaction with their current practice opportunities. Education and training rate highest, followed by community psychiatry and family psychiatry. Thus, any reorganization of psychiatric services that provides opportunities for work in these areas could be expected to be received positively by psychiatrists. Relatively few psychiatrists are looking for opportunities to become involved in psychoanalysis. This probably can be explained by the fact that Ontario has lost to the United States¹ many psychiatrists who are interested in

¹W. E. Powles, "The Movement of Canadian Physicians to Psychiatric Practice in the United States". An address to the Ontario Psychiatric Association, Toronto, February 1, 1969.

psychoanalysis and psychodynamics, as a result of the dominance of mental hospital psychiatry in Ontario. Child psychiatry, public health, industrial psychology and mental retardation also rank low, but for other reasons.

These data can be compared with data concerning areas of major interest among psychiatrists, presented in Table 4.4.

TABLE 4.4
Areas of Major Interest in Psychiatry for Ontario Psychiatrists

Nature of area	Positive responses		Negative responses		No responses	
	No.	%	No.	%	No.	%
General psychiatry	121	81.2	11	7.4	17	11.4
Education and training	84	56.4	26	17.4	39	26.2
Family psychiatry	82	55.0	25	16.8	42	28.2
Community psychiatry	81	54.4	28	18.8	40	26.8
Adolescent psychiatry	75	50.3	29	19.5	45	30.2
Child psychiatry	47	31.5	55	36.9	47	31.5
Psychoanalysis	43	28.9	102	68.5	4	2.7
Forensic psychiatry	41	27.5	56	37.6	52	34.9
Public health	26	17.4	65	43.6	58	38.9
Mental retardation	19	12.8	71	47.7	59	39.6
Industrial psychiatry	6	4.0	82	55.0	61	40.9

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

Tables 4.3 and 4.4 are organized according to the magnitude of positive responses. A number of aspects of current psychiatric practice in Ontario emerge from a comparison of these tables. As one would expect, general psychiatry rates by far the highest in terms of major interest, while it rates quite low in terms of practice preference. The reason for this is, of course, that psychiatric services in Ontario offer ample opportunity for a generalized psychiatric practice combining hospital and some private practice.

Because the subspecialties have developed most recently, opportunities for their practice are not plentiful. There is some difference of opinion among psychiatrists themselves concerning the emphasis that the subspecialties should receive as compared to general psychiatry. Numerous psychiatrists voiced the opinion, as did some general practitioners and medical specialists, that what is most needed is more good general psychiatrists. Nevertheless, the Ontario Psychiatric Association actively encourages the growth of subspecialties around therapeutic techniques

(such as psychotherapy) and subdisciplines (such as child psychiatry) by facilitating the formation of groups of psychiatrists with special interests and expertise in these fields.

It would seem reasonable, *prima facie*, that both general psychiatry and subspecialties are needed, and that general psychiatry will benefit from the growth now taking place in the subspecialties through training programs strengthened by the expertise of the area specialist.

Of the eighty-four psychiatrists in the sample who take an active interest in training and education, a substantial number — sixty-three — would like to be able to devote more time to training and education than the conditions of their practice permit. The generality of this attitude has been demonstrated in practical terms by educational ventures such as D. McCulloch's program of psychiatric case seminars for general practitioners.² (This program is discussed in more detail in Chapter 14.) Psychiatrists have shown a willingness to make a special effort in this area, in order to try to improve the general quality of psychiatric care being offered by various individuals and agencies throughout the province.

As was expected from field interviews, attitudes among psychiatrists are most sharply polarized in relation to psychoanalysis. One hundred and two psychiatrists indicated no interest in psychoanalysis, forty-three indicated an interest, and four made no response. Since all other categories had many more "no responses" and fewer negative responses, a negative response here can be read as "positively no interest". The other less popular areas — child psychiatry, forensic psychiatry, public health, mental retardation and industrial psychiatry — have each scarcely fewer "no responses" than "negative responses".

It is surprising that this situation should still exist in psychiatry over half a century after the introduction³ of psychoanalysis into Ontario. It probably results in part from the domination of training in psychiatry by residency in the Ontario Hospitals. In the opinion of psychiatrists who have received this training, it provided a grossly inadequate preparation for the diagnostic and therapeutic work of a diversified psychiatric private practice, which always involves large numbers of neurotic patients, the treatment of whom is based on a psychodynamic rather than a physiological-management-custodial approach. (Psychoanalysis as a body of scientific knowledge is usually the basis of the psychodynamic approach in psychiatry.) This state of affairs, which places Ontario well behind similar jurisdictions (Quebec in Canada, and Massachusetts, Connecticut and New York in the United States), justifies completing the transition to university-controlled training in psychiatry as soon as possible.

²D. J. McCulloch, "Psychiatric Seminars for General Practitioners", *Canadian Medical Association Journal*, Vol. 94, 1966, pp. 235-237.

³By Ernest Jones, who was appointed to the Department of Psychiatry at the University of Toronto about 1910.

Although psychiatry in Ontario has not been a congenial environment for the development of psychoanalysis, forty-three respondents, or 29 per cent, expressed an interest in psychoanalysis. Only two psychiatrists in the sample were qualified psychoanalysts, and three others were in training to become psychoanalysts.

The three areas that psychiatrists find least interesting are public health, mental retardation and industrial psychiatry. It must be noted, however, that community psychiatry is very much public health oriented, because of its strong emphasis on early detection, prevention and crisis management in the community rather than on hospitalization.

The fact that relatively few psychiatrists are interested in public health in the more traditional sense does not mean that psychiatrists are not interested in the extension of psychiatric services into the community through community clinics, emergency service and public education in mental health. On the contrary, a strong trend of interest has been indicated leading away from mental hospital psychiatry in the direction of community clinic and preventive services. Eighty-one psychiatrists in the sample take a major interest in community psychiatry, and forty of these would welcome an opportunity to devote more of their practice to this work.

To a lesser extent the same applies to industrial psychiatry. This branch of psychiatry, which is concerned with the effects of employment conditions on the mental health of employees and the effects of mental illness in employees on employment conditions, is a logical extension of community psychiatry.

Since retardation forms a very small fraction of the population of the psychologically disadvantaged and the mentally ill, it is not surprising that relatively few psychiatrists take a major interest in it. Insofar as mental retardation is a chronic handicap, the treatment of which requires special educational skills rather than medical treatment, clinical psychologists with a background in learning theory might be better equipped by training to treat these persons.

In summary, the major interests of psychiatrists fall into three groups, as follows: most frequent interest — general psychiatry, education and training, family psychiatry, community psychiatry, adolescent psychiatry; of intermediate frequency — child psychiatry, psychoanalysis, forensic psychiatry; least frequent interest — public health, mental retardation, industrial psychiatry.

Frequency of Different Types of Mental Illness Treated

What kinds of illness do Ontario's psychiatrists see within the general framework of psychiatric practice, and what is the relative frequency of the various major types of psychiatric disorder (psychosis, psychoneurosis, character and behaviour disorder, others) in their practices? Both the OMSIP Diagnostic Data Analysis (Study 1) and the Mental Health Survey: Psychiatrists (Study 2) provided data concerning these questions.

TABLE 4.5
Diagnosis of Psychiatric Disorders by Psychiatrists,
Primarily in Private Practice

Psychiatric diagnosis	Percentage of all psychiatric diagnosis
Psychosis	13
Psychoneurosis	78
Character and behaviour disorders	7
Other	2
Psychological disorders with organic causes ¹	0

¹Only ten cases of psychological disorders with organic causes were reported out of a total of 5,489 for the period of the study.

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967. Based on OMSIP claim cards of patients of psychiatrists, May 1–October 31, 1967.

Table 4.5 reflects psychiatric private practice and general hospital practice only, since mental hospital practice and community clinic practice are based on contracts with the Department of Health and are not, in consequence, insurable by OMSIP. The following two tables based on the Mental Health Survey: Psychiatrists include mental hospital psychiatry. None of the tables is based on private practice alone, but they can be scaled as follows: Table 4.5 is predominately private practice; Table 4.6 is intermediate between private practice and hospital practice; Table 4.7 is predominantly hospital practice.

By comparing these tables we can make a number of generalizations which confirm opinions and impressions gathered in the course of our study. Private practice in psychiatry is involved primarily with the treatment of psychoneurotic disorders. The OMSIP data, from which Ontario Hospital psychiatry is excluded, show that 78 per cent of the patients seen by psychiatrists are psychoneurotic patients. By contrast Table 4.6, which reflects a greater admixture of community clinic and hospital practice, shows psychoneurotic patients reduced to 49 per cent,

TABLE 4.6
Diagnosis of Psychiatric Disorders by Psychiatrists
in Private Practice and Hospital Practice

Psychiatric diagnosis	Percentage of all psychiatric diagnosis
Psychosis	17
Psychoneurosis	49
Character and behaviour disorders	27
Other	5
Psychological disorders with organic causes	2

SOURCE: C. Hanly and W. Christian, Mental Health Survey: Psychiatrists (Study 2), 1967. Based on a questionnaire survey of Ontario psychiatrists.

TABLE 4.7
Diagnosis of Psychiatric Disorders by Psychiatrists,
Primarily in Hospital Practice

Psychiatric diagnosis	Percentage of all psychiatric diagnosis
Psychosis	21
Psychoneurosis	37
Character and behaviour disorders	32
Other	8
Psychological disorders with organic causes	2

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
 Based on a questionnaire survey of Ontario psychiatrists.

with corresponding increases in psychosis and character and behaviour disorders. This tendency occurs also in Table 4.7. As the amount of private practice reflected in the data is decreased, the percentage of psychoneurotic cases undergoes a further decrease to 37 per cent, with increases in psychotic cases to 21 per cent and increases in character and behaviour disorders to 32 per cent.

Methods of Treatment

Treatment methods vary greatly among psychiatrists depending on the nature of their training, their interests and their practice setting. They may range from the psychiatrist who is also a psychoanalyst and works with perhaps eight patients, providing consultations or short-term psychotherapy to a few others, to the psychiatrist who supervises the care of perhaps 500 chronic hospitalized patients, many of whom are geriatric cases. At the one pole the psychiatrist is a highly trained specialist who provides a highly specialized form of treatment; at the other pole he is scarcely distinguishable from the traditional alienist, and the nature of the practice is almost entirely medical in the narrow sense. Many variations and combinations of treatment methods and practice settings are to be found between these two polarities. Psychotherapy dispensed in an outpatient clinic or private practice dominates the psychoanalytic end of the spectrum, and the use of electroconvulsive therapy (ECT) to relieve depression and the treatment of psychosis by means of drugs in an inpatient service dominates the medical end. Table 4.8 lists the different treatment methods and combinations of treatment methods, and the number of psychiatrists using them to treat different numbers of patients ranging from 0 up to 45.

In three respects Table 4.8 does not perfectly reflect the data: some psychiatrists (very few) reported more than forty-five patients in treatment by one or other of the methods itemized; some psychiatrists (again very few) itemized a therapy (such as LSD) that was not enumerated; finally, it will be noticed that the figures in the last two columns when added horizontally total in some cases 150 and in others 145. The first two sources of imperfection were caused by a

Frequency in Use of Various Treatment Methods by a Group of Ontario Psychiatrists (for one-week period)

Treatment method	Number of patients										Total patients	Total psychiatrists	Psychiatrists not using methods
	1-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	46-50			
Psychotherapy (individual)	30	34	17	14	5	3	3	4	5	—	1,444	115	30
Psychotherapy (group)	10	25	7	5	1	1	1	—	1	—	502	51	94
Psychoanalysis	3	—	—	—	—	—	—	—	—	—	15	3	142
Counselling (individual)	31	10	—	1	1	2	—	—	—	—	260	45	100
Counselling (group)	4	4	—	—	1	—	—	—	—	—	64	9	136
Narcoanalysis	14	—	—	—	—	—	—	—	—	—	35	14	136
Insulin shock	6	—	—	—	—	—	—	—	—	—	15	6	144
ECT	36	7	3	—	—	—	—	—	—	—	185	46	99
Surgery	5	—	—	—	—	—	—	—	—	—	12	5	140
Behaviour therapy	21	1	2	1	—	—	—	—	—	—	108	25	125
Hypnosis	11	—	—	—	—	—	—	—	—	—	30	11	139
Drug therapy	25	12	9	6	1	2	4	1	4	—	808	64	81
Play therapy	15	2	3	—	—	—	—	—	—	—	108	20	130
Milieu therapy	7	8	6	7	1	2	2	—	—	—	415	33	117
Drug and psychotherapy (individual)	35	10	15	10	3	5	2	5	3	—	1,110	88	57
Drug and psychotherapy (group)	11	4	1	4	—	1	1	1	—	—	233	23	122
ECT and drug therapy	27	5	3	—	—	—	—	—	1	—	185	36	109
Milieu and psychotherapy (individual)	16	7	2	3	—	—	—	—	—	—	179	28	122
Milieu and drug therapy	17	6	4	3	1	—	1	—	—	—	237	32	118
Milieu, drug and ECT	26	1	2	—	—	—	—	—	—	—	97	29	121

SOURCE: C. Hanly and W. Christian, Mental Health Survey: Psychiatrists (Study 2), 1967. Based on a questionnaire survey of Ontario psychiatrists.

storage problem on the IBM cards used to analyze the data. Encoding highly unusual items was not practicable. The third source of imperfection results from the omission by five respondents of information concerning their residential training; their questionnaires were rejected by the computer when it performed the analysis. These defects do not impair the data for the purposes of this report, because their exclusion does not materially affect our interpretations.

The most important conclusion is that the psychological content of psychiatric treatment greatly outweighs the strictly medical content, whether one uses the number of psychiatrists who use a psychological as compared to a physiological therapy or the number of patients as the measure. Psychological treatments include individual and group psychotherapy, psychoanalysis, individual and group counselling, hypnosis, play therapy, milieu therapy, and milieu and psychotherapy; physiological (strictly medical treatments) include insulin shock, ECT, surgery, drugs, and any combinations of them; methods involving both physiological and psychological components are narcoanalysis, behaviour therapy, and combinations such as drugs and psychotherapy, or milieu and drug therapy.

Individual psychotherapy is by far the most commonly used treatment method in any of the three general categories, from the point of view of the number of patients so treated or the number of psychiatrists using it as a treatment method. Of the 145 psychiatrists in the sample, 115 treat some patients at least by one-to-one psychotherapy, and together they treat a total of approximately 1,444 patients. Individual psychotherapy is used almost twice as much by almost twice as many psychiatrists as its closest physiological treatment rival — drug therapy — which sixty-four psychiatrists used to treat approximately 808 patients. Eighty-one psychiatrists in the sample were not using drugs at all, while thirty were not using individual psychotherapy as a treatment method.

This finding has two implications. First, thorough theoretical and clinical training in psychodynamics and psychotherapy is an essential component of any psychiatric curriculum. Second, a *uniquely* psychological mode of treatment which does *not* involve the prescription of drugs or physical examinations (which are strictly medical procedures) is the major single form of treatment in psychiatry in Ontario, despite the dominance of mental hospital and general psychiatry in the training and service traditions of the province. This conclusion has the further implication that *in principle*, psychiatrists could share a substantial part of their therapeutic work with non-medical psychotherapists.

These inferences are reinforced by the further consideration, derived from Table 4.8, that the psychological therapies as a group were used by the psychiatrists in the sample to treat 3,017 patients, whereas the physiological therapies were used to treat 1,205 patients. In addition, mixed physiological and psychological therapies were used to treat 1,820 patients; and, with the exception of behaviour therapy and narcoanalysis, most of the other therapies *in principle*

could be conducted on a partnership basis, with the psychological therapeutic component conducted by a non-medical psychotherapist and the medical component administered by a psychiatrist.

It is difficult to delineate accurately the uses by psychiatrists of the different treatment methods for the diverse forms of mental illness. The quality of the data in the questionnaires on this subject was distinctly inferior, because it was difficult for some psychiatrists to categorize their work in the terms provided by the questionnaire. Table 4.9, which is presented subject to these qualifications, generates some useful generalizations.

The "no response" column is ambiguous in this table, since it includes both respondents who were not using the treatment method in question, and respondents who were using the treatment method but did not specify for what conditions they were using it. The enumeration of disorders includes compounded categories as well as univocal categories. The compounded categories indicate, not the use of the treatment method for patients in whom both disorders occur, but the use of the treatment method for both disorders. For example, the category "psychosis and depression" should be read as meaning that the treatment method is used for treating psychosis *and* for treating depression, which may be a symptom of psychosis or psychoneurosis. The inclusion of milieu therapy in the list of psychiatric treatments is somewhat arbitrary, because it is viewed by many as essentially a "care" rather than a "treatment" program; it is limited to hospital wards and, consequently, to hospitalized patients. In many hospital wards milieu therapy is built into all aspects of the care environment of the ward, so that all patients automatically receive it.

Table 4.9 indicates that the prevailing tendency in psychiatry is to use psychological therapies (milieu therapy excepted) for the treatment of neuroses and character and behaviour disorders, and to use physiological treatment methods for the treatment of the psychotic disorders which are thought to be largely organically determined. Among the physiological therapies, electroconvulsive therapy is widely used for the specific symptom of depression, which may be associated with a neurosis as well as a psychosis.

Attitudes to Training and Use of Therapies

What is the attitude of psychiatrists to their own professional training in relation to their professional practice? In particular, is medical training considered a prerequisite for the adequate performance of various crucial diagnostic and treatment tasks? Certain treatments such as insulin shock, electroconvulsive therapy or surgery are so clearly medical procedures that there can be no question about them. But other even more important tasks and treatment procedures, as measured by the frequency of their use and the range of conditions they can be used to treat, may be thought to be tasks that can be adequately performed without the

TABLE 4.9

**Use of Therapies for the Treatment of Psychiatric Disorders
by Psychiatrists in Ontario**

Treatment method	Nature of disorder or symptoms				
	Psychosis	Neurosis	Character and behaviour disorder	Psychosis and neurosis	Psycho- and charac- and behavio- disorder
Individual					
psychotherapy	1	54	2	19	2
Group					
psychotherapy	3	10	8	7	2
Psychoanalysis	—	4	—	—	—
Individual					
counselling	3	18	5	2	—
Group					
counselling	—	4	2	—	—
Narcoanalysis	—	10	1	—	—
Insulin shock	—	4	—	—	—
ECT	14	1	—	—	—
Surgery	—	3	—	—	—
Behaviour therapy	1	13	3	—	—
Hypnosis	—	9	—	—	—
Drug therapy	11	3	—	21	2
Play therapy	1	2	14	—	—
Milieu therapy	1	1	4	4	—
Drug and individual					
psychotherapy	10	14	3	36	—
Drug and group					
therapy	2	4	—	3	—
ECT and drug					
therapy	9	1	—	3	—
Milieu and individual					
psychotherapy	—	5	6	4	—
Milieu and drug					
therapy	7	5	3	6	1
Milieu, drug, ECT	12	—	—	4	—

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
Based on a questionnaire survey of Ontario psychiatrists.

Neurosis and character and behaviour order	All forms	Organically caused conditions	Alcoholism	Depression	Psychosis and depression	No response
27	16	—	—	1	—	29
4	11	—	—	—	—	95
—	1	—	—	—	—	145
6	9	—	3	—	1	103
—	2	—	—	—	—	142
2	2	—	—	—	—	135
1	—	—	—	—	—	145
—	1	—	—	14	15	105
—	—	—	—	—	—	147
4	2	2	—	—	—	125
—	2	—	—	—	—	139
3	20	2	1	1	7	79
4	1	—	—	—	—	128
4	20	1	—	—	—	115
9	16	—	2	2	1	57
3	8	1	2	1	—	125
—	3	—	—	5	15	113
4	9	—	—	—	—	121
2	7	2	—	—	2	114
—	4	—	—	4	4	121

medical training that every psychiatrist must have and, hence, can be classified, from a scientific point of view, at least, as interdisciplinary services. Table 4.10 reports the results of the questionnaire survey on this question.

TABLE 4.10
Opinion of Ontario Psychiatrists on the Need for Medical Training

Nature of service	Medical training as a prerequisite for performing the service					
	Affirmative No.	%	Negative No.	%	No Response No.	%
Psychiatric diagnosis	142	95.3	7	4.7	—	—
Psychoanalysis	37	24.8	100	67.1	12	8.1
Milieu therapy	11	7.4	125	83.9	13	8.7
Behaviour therapy	12	8.1	127	85.2	10	6.7
Play therapy	7	4.7	134	89.9	8	5.4
Individual counselling	9	6.0	132	88.6	8	5.4
Group counselling	5	3.4	136	91.2	8	5.4
Psychotherapy	90	60.4	53	35.6	5	3.4
Prescribe psychotropic drugs	124	83.2	22	14.8	3	2.0

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
Based on a questionnaire survey of Ontario psychiatrists.

In order to interpret these data it is necessary to arrive at a precise definition of what constitutes a psychiatric diagnosis. A diagnosis leading to the establishment of a treatment for a pathological condition of any kind will consist theoretically of two basic elements: the investigation of physical determinants, and the investigation of psycho-social determinants. In some cases one set of determinants will obviously predominate over the other. A traffic accident victim who has suffered lacerations will present a set of physical problems to the physician in an emergency department. But even here psycho-social determinants cannot be overlooked, if the health and safety of the patient are to be considered. He may have been the victim of his own negligence, and his negligence may have been caused by a psychopathological disturbance. Repairing the damage presents a narrowly medical problem, but helping the individual to avoid damage of a similar kind in the future requires an additional diagnosis and the treatment of the motivational disturbance. This second investigation, the psychiatric diagnosis, falls into two parts. The first seeks to determine whether the observed psychological disturbance is caused by some organic condition. Such factors having been identified or ruled out, the second and final step consists of the examination of the psychological disturbance itself in order to determine its nature and possible psychological cause, and the type of treatment best calculated to bring about an improvement.

There is, therefore, some ambiguity in the concept of a psychiatric diagnosis. It can be clarified by differentiating between a psychiatric and a psychological

TABLE 4.11
Degree of Utilization of Clinical Psychologists by Psychiatrists

Type of utilization	Percentage of psychiatrist's patients seen by clinical psychologist									
	0	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-
Diagnosis	12	31	16	10	4	17	5	2	4	14
Therapy	44	33	12	19	3	4	1	—	—	3
General care	104	8	—	1	1	1	—	—	—	—

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

diagnosis. A psychiatric diagnosis includes the investigation of organic factors as well as the investigation of psycho-social factors. A psychological diagnosis consists of the investigation of psychological determinants. For the purpose of this study the term "psychodiagnosis" will have the same meaning as "psychological diagnosis". The implication of this terminology is that a medical degree is a prerequisite for a psychiatric diagnosis, but not for a psychological diagnosis.

At the same time it must be fully appreciated to what extent clinical psychologists may either contribute substantially to, or undertake themselves, psychiatric diagnoses in the sense defined above. In field interviews numerous psychiatrists as well as psychologists reported that the clinical psychologist's diagnostic skills are especially useful when an organic determinant of a psychiatric disorder, such as brain damage, is suspected. A number of psychologists working in hospitals claimed that patients presenting difficult diagnostic problems were sent to them routinely by psychiatrists for an opinion. This practice may well be reflected in the responses from seven psychiatrists who do not think that a medical degree is, from a scientific point of view, a prerequisite for performing a psychiatric diagnosis.

A superficial examination of the responses indicates a major inconsistency between responses concerning psychotherapy and those concerning psychoanalysis

TABLE 4.12
Degree of Utilization of Psychiatric Social Workers by Psychiatrists

Type of utilization	Percentage of psychiatrist's patients seen by clinical psychologist									
	0	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-
Diagnosis	39	22	9	10	5	7	1	4	6	10
Therapy	28	24	13	15	4	13	3	2	6	7
General care	70	15	5	12	3	4	1	—	1	4

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

with respect to whether or not a medical training is a prerequisite for their performance. The implications of this and certain other inconsistencies will be examined below.

Interprofessional Cooperation

Tables 4.11 and 4.12 reflect the amount of diagnostic work done conjointly by psychiatrists with clinical psychologists and social workers. The psychiatrists in the group are limited to those who do some hospital practice, because private practitioners, as will be shown subsequently, are involved very little in interprofessional work.

Table 4.11 indicates that of the subset of 115 psychiatrists from the total sample only twelve did not utilize clinical psychologists for the diagnosis of any patients, while forty-four did not utilize clinical psychologists for the treatment of any of their patients. In general, the utilization of psychologists by psychiatrists is heavily weighted towards diagnosis. When asked if they would use clinical psychologists more, if more were available, eighty-seven of the psychiatrists replied that they would, twenty-one said that they would not, and five gave no reply.

When Table 4.12 is compared with Table 4.11, it appears that there is a slightly greater utilization of psychiatric social workers by psychiatrists for therapy and a correspondingly lesser utilization for diagnosis of patients. When asked if they would use psychiatric social workers more, if more were available, eighty-eight of the psychiatrists replied that they would, seventeen said that they would not, and eight gave no reply.

A comparison of these tables with the tables for the utilization of social workers and psychologists by psychiatrists who have no private practice shows to what extent the utilization by psychiatrists of social work and psychological services is linked to the hospitals. Seventy-four, eighty-seven and forty-five psychiatrists in the group with some hospital practice reported working with social workers

TABLE 4.13
Attitudes of Psychiatrists to the Question:
"Should Mental Health Services by Psychiatric Social Workers
Be Rendered only on Referral from Physicians?"

	Yes		No		No reply		Total
	No.	%	No.	%	No.	%	
Psychiatrists:							
hospital group	69	60.0	41	35.7	5	4.3	115
Psychiatrists:							
private practice group	69	67.0	29	28.2	5	4.9	103

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
Based on a questionnaire survey of Ontario psychiatrists.

in the three areas of diagnosis, therapy and general care and 103, seventy-five and eleven reported working with clinical psychologists in the same areas. The corresponding figures for psychiatrists in the private practice group were twenty-five, twenty-nine and eleven respectively for social workers and sixty-six, sixteen and one respectively for psychologists.

Despite the marked difference between hospital and private practice, many of the psychiatrists in the private practice group would like to be able to involve social workers and psychologists in their diagnostic and therapeutic work more than the supply of these professionals allows. Seventy-seven of the 103 psychiatrists in this subset said they would use psychiatric social workers more if more were available, nineteen said that they would not, and seven gave no reply. And of the seventy-two psychiatrists in the same group, forty-one said they would use clinical psychologists more, if more were available, twenty-three said that they would not, and eight gave no reply.

Clearly then, many psychiatrists are prepared to work with social workers and psychologists. This finding is of particular interest, since one of the frequent criticisms of psychiatrists by their medical colleagues is that psychiatrists do not use the resources of clinical psychologists and social workers enough. Most psychiatrists, however, felt that the mental health diagnostic and therapeutic services of social workers and clinical psychologists should be rendered only on referral from a physician, thus linking their practice to medicine. Attitudes on this question are tabulated in Tables 4.13 and 4.14. A substantial majority of psychiatrists consider it essential that every person treated by a psychiatric social worker or a clinical psychologist for a psychiatric disorder should have first been examined by a physician and referred to him for this purpose.

Assessment of Training

Some psychiatrists are reluctant to utilize psychologists for certain therapeutic purposes because they doubt the adequacy of their training, especially in psycho-

TABLE 4.14
Attitudes of Psychiatrists to the Question:
"Should Mental Health Services by Clinical Psychologists
Be Rendered only on Referral from Physicians?"

	Yes		No		No reply		Total
	No.	%	No.	%	No.	%	
Psychiatrists:							
clinical group	76	66.1	33	28.7	6	5.2	115
Psychiatrists:							
private practice group	73	70.8	24	23.3	6	5.8	103

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
Based on a questionnaire survey of Ontario psychiatrists.

TABLE 4.15
Evaluation of Professional Training by Psychiatrists

Training program	Excellent		Good		Fair		Poor		Unknown		No reply	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Psychiatry	14	9.4	83	55.7	32	21.5	12	8.1	7	4.7	1	0.7
Psychiatric social work	5	3.4	44	29.5	56	37.6	20	13.4	18	12.1	6	4.0
Clinical psychology	4	2.7	40	26.8	51	34.2	35	23.5	13	8.7	6	4.0
Psychotherapy	3	2.0	24	16.1	66	44.3	44	29.5	9	6.0	3	2.0

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

therapy. The rating by psychiatrists of the quality of training in Ontario of other mental health professions as compared with their own and, in particular, with the psychotherapy component in their own, is of some interest.

Although training programs in psychiatric social work and clinical psychology are thought to be as good as those in psychiatry, the component of psychiatric training in the area of overlap with clinical psychology and psychiatric social work — namely, psychodynamics — is thought by most psychiatrists to be only fair or poor.

Criteria for Referral of Patients

The criteria for referral to a psychiatric social worker adopted by psychiatrists in the sample can be analyzed in the following groups, arranged in descending order of importance as measured by the frequency with which each criterion was mentioned in the questionnaires.

- 1) Family counselling with the family as the patient unit.
- 2) Social casework including taking case histories and supportive psychotherapy *and* liaison with the family of hospitalized patient.
- 3) Presence of a social problem which requires the mobilization of community resources.
- 4) Group or short-term individual therapy similar to that done by the psychiatrist himself (if the social worker is a qualified therapist) when the psychiatrist cannot keep pace with the case load.
- 5) Counselling in the absence of psychiatric pathology and/or organic illness.

The frequency with which these criteria were mentioned was as follows: 1) seventy-eight; 2) sixty-four; 3) fifty-three; 4) forty-six; 5) thirteen. The criteria are not perfectly interconnected, in that a psychiatrist referring to social workers on the basis of 5) may or may not be prepared to ask a social worker to give

psychotherapy even if he were trained. The same would apply to criterion 3). However, they form a consistent set of standards which emphasizes the societal orientation of the social worker's diagnostic skills; the special knowledge of the total socio-economic context of the patient and his family; the special orientation of the social worker towards the family unit; and the social worker's capacity to give group or individual psychotherapy when specially trained to do so.

The criteria for referral to clinical psychologists reflect the difference in training and expertise between psychologists and social workers on the one hand, and psychologists and psychiatrists on the other:

- 1) Intelligence, perception and aptitude testing.
- 2) Testing for organic impairment.
- 3) Personality assessment.
- 4) Psychotherapy (if the psychologist is properly trained, and if there are no medical complications involved in the illness or a need for medication).
- 5) Behaviour therapy, milieu therapy, counselling.

The frequency with which these were mentioned was 1) 135; 2) 104; 3) eighty-nine; 4) sixty-one; 5) four. The particular diagnostic skills of the psychologist appear to be his most valued asset as far as psychiatrists are concerned, including testing for organically determined psychological defects or disorders. The utilization of psychologists for therapy is subject to the limitation that the disorder must be strictly psychogenetic in nature and entirely psychological in mode of treatment before it can be safely left to the clinical psychologist, assuming that he has been properly trained to do psychotherapy. The criteria and the weight given to them are surely above criticism and quite accurately reflect the current nature of the training preparation of most clinical psychologists; the exception is those who have been trained in some of the better American graduate schools, where they are able to receive advanced training in psychodynamics and psychotherapy. As the field interviews showed, it is generally agreed that clinical psychologists are unequalled in the mental health professions in many areas of research because of the emphasis placed on experimental design and the mathematical analysis of data in their postgraduate programs. A leading American clinical psychologist suggested that the conflict between psychology and psychiatry in the United States over the spoils of private practice is rapidly being resolved as vast sums of federal money begin to flow into mental health research. The next conflict will be over the control of these new financial resources. The United States is well ahead of Canada, however, in its resources and its conflicts.

Location of Psychiatrists in Ontario

Forty-three per cent (157 of 367) of Ontario's psychiatrists are located in Metropolitan Toronto.

This concentration of psychiatrists in Toronto makes for a serious inequality in the availability of basic mental health services within the province. The population of Metro during the summer of 1967 was approximately 2,210,000. The balance of the province's population was 4,939,000. The result is a ratio of one psychiatrist for every 14,076 persons in Metro. The ratio for the balance of the province is one to 23,518.

Yet this way of representing the inequality is still somewhat misleading. Four other cities outside Toronto enjoy the services of another 106 of the province's psychiatrists: Hamilton, Ottawa, Kingston and London have twenty-one, twenty-seven, twenty-six, and thirty-two psychiatrists respectively, with metropolitan populations of 458,104, 505,290, 59,917 and 211,748 respectively (as of summer 1967). The ratio of psychiatrists to population were as follows: Hamilton, 1:21,814; Ottawa, 1:18,714; Kingston, 1:2,305; London, 1:6,617. The remainder of Ontario's population is served by 104 psychiatrists, providing a psychiatrist:patient ratio of 1:35,613. Thus, Ontario's rural population is disadvantaged relative to urban populations with respect to the availability of psychiatric services in the community. Northern Ontario generally is disadvantaged relative to southern Ontario.

This inequality is readily explained. The distribution of psychiatrists is determined by three major factors: a preference common to most highly-trained professionals for urban life; the location of universities with medical schools and teaching hospitals; the location of large mental hospitals. Toronto, Kingston, London and Ottawa meet all these criteria. Hamilton, until very recently, has not had a university medical school and teaching hospitals and, in the absence of these facilities, has had the worst ratio of psychiatrists to population of the metropolitan areas studied. In contrast London, which has a large medical school, two large teaching hospitals and a number of major Department of Health institutions in a relatively small metropolitan area, and Kingston, which enjoys a similar situation, have by far the best ratios of psychiatrists to immediately surrounding population. It is predictable that Hamilton will make rapid improvements with the establishment of a vigorous new medical school and a Department of Psychiatry at McMaster University. One aspect of the severe manpower shortage in psychiatry is gross inequality in the distribution and availability of the necessary range of psychiatric services throughout the province.

Some Crucial Issues

Implicit in these data are some issues of crucial importance to any consideration of training, licensing, regulation and merit of service in psychiatry. These issues must now be considered in detail. First among them is the specification of the shortage of psychiatrists which takes up the problem broached in Part One.

Effects of Unequal Distribution of Psychiatrists

Some of the specific manifestations of this problem and its adverse effects on the

services rendered will be documented in the more detailed sections that follow. The data derived from a questionnaire distributed to a sample of the province's general practitioners and selected specialists (general surgeons, orthopaedic surgeons, internists, neurologists, obstetricians and gynaecologists) confirm the serious general shortage of psychiatrists and the unequal distribution of available resources (see Table 4.16). Physicians were asked to rate the quality of psychiatric services in the vicinity of their practice.

TABLE 4.16

Rating of Local Psychiatric Services by a Sample of Physicians in Ontario

Type of physician	Excellent	Good	Adequate	Inadequate	Very inadequate	None	No response	Do not know
Percentage of G.P.'s	7	22	28	30	11	2	0	0
Percentage of G.P.'s and specialists	12	24	25	27	7	3	2	0

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians.

A positive correlation was found between the location of the physician's practice in a rural area and dissatisfaction with psychiatric services. This also explains the variation in the percentage figures when the specialists in the sample are included, since they, like psychiatrists and for similar reasons, are located largely in the cities and the hospitals where most of the psychiatrists are. The current dissatisfaction among other medical practitioners with psychiatric services is to be explained almost entirely by the serious general and local shortage of psychiatrists and *not* as an adverse judgement on the work done by psychiatrists now in practice. This interpretation was validated by a content analysis of the open comments section of the same questionnaires. Among the uninvited comments were numerous statements to the effect that the rating of inadequate or very inadequate meant dissatisfaction, not with the services rendered by psychiatrists, but with the short supply of psychiatrists to render them. This interpretation was substantiated also by the frequency with which, in the open comments portion of the questionnaire, the physicians in the sample availed themselves of the opportunity to register their perception of the need for more psychiatrists. Not all respondents used the open comments section, but when they did, "more psychiatrists needed" was by far the most frequent comment. An analysis of the contents of the open comments section is contained in Table 4.17, in which suggestions for improvement in mental health services are compared with respect to the frequency of their occurrence.

It is clear that, directly or indirectly, comments on the need for more outpatient clinics, improved emergency services, improved special services, and more

TABLE 4.17
Need for Improvement in Psychiatric Services as Perceived by a Sample of Ontario Physicians

Nature of the need cited	Frequency of Citation	
	No.	%
More psychiatrists	157	23.8
More outpatient clinics	115	17.5
More paramedical professionals	32	4.9
Greater utilization of G.P.'s	29	4.4
More hospital beds for psychiatric patients	29	4.4
Improved emergency services	27	4.1
More contact with psychiatrists	21	3.2
Improved special services ¹	24	3.6
Hospital privileges ²	12	1.8

¹Special services referred to items such as alcoholics' clinics, treatment centres for emotionally disturbed children, rehabilitation centres, and the like.

²Some general practitioners would like to be able to admit psychiatric cases to psychiatric wings of general hospitals and participate in their treatment.

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians. (Total number in sample, 659.)

contact with psychiatrists imply that more psychiatrists are needed; for these improvements will require an increase in the numbers of psychiatrists. It must be pointed out that these figures are not simply additive, since two or more such comments could occur on one questionnaire. Nevertheless, by the interpretation placed on the assessment of psychiatric services in the questionnaires, a serious general and local shortage of psychiatrists is indicated.

Yet another aspect of the problem is the fact that the many psychiatrists who are not working in the five metropolitan areas of Toronto, Hamilton, London, Kingston and Ottawa are working in provincial mental hospitals as employees of the Department of Health. Their services are not available to the communities in which they are located unless through hospitalization or through the outpatient department of the hospital. One hundred of Ontario's psychiatrists are full-time employees of the Department of Health-operated mental hospitals. Fifty are part-time employees. All are involved in providing inpatient services; thirty-five provide *some* service to outpatient clinics in some twenty different Ontario hospitals. But there are currently twenty-one vacancies for psychiatrists in these services at present levels of service and of physician:patient ratios. More, rather than fewer, psychiatrists are needed in the services providing treatment for illnesses that require hospitalization. Thus, most of the province's rural, small town and small city population has available to it only understaffed hospital-oriented services.

This situation has a number of specific additional disadvantages. Although the social stigma attached to the "loony bins" operated by the Department of

Health may have been somewhat diminished by their improvement and modernization and by the general improvement in public attitudes towards mental illness, it is still sufficient to act as a deterrent to persons seeking needed help. Furthermore, the mental hospitals are necessarily and properly oriented towards the treatment of psychosis and the more severe forms of character and behaviour disorders; they are not well suited to treat psychoneurotic disorders.

The optimal treatment for severe psychoneurosis is psychoanalysis. Psychoanalysis is available only in Toronto and Ottawa, although there is the prospect of its becoming available in Hamilton and Kingston. The most desirable treatment for psychoneurotic disorders of lesser severity, emotional and behaviour disturbances in children, and behaviour problems such as alcoholism is psychotherapy. These services, while available in some of Ontario's communities, are still grossly undersupplied to most of the province's population. These treatments do not require a hospital setting. In fact the best setting is the privacy of the office of a psychiatrist, psychoanalyst or psychologist, or the semi-privacy of a community mental health clinic. If the mental health needs of Ontario's population living outside the five urban centres are to be equitably served, *more* psychiatrists in private practice and in community mental health clinics are required.

It does not follow, however, nor is it suggested, that Ontario's major urban centres have enough psychiatrists. In order to provide front-line therapeutic services of the highest possible quality to patients, there must be not only therapists but also researchers, teachers and administrators. It is all to the good that senior therapists feel an obligation to teach their skills to others and to spend some time in research. Progress and improvement in quantity and quality of service demand it. Yet time so spent must be subtracted from service to persons in need of therapy. Furthermore, the large Ontario hospitals in these urban centres often serve very large surrounding rural populations for the treatment of psychiatric disorders requiring hospitalization. Consequently, although they are much better serviced than rural areas, the urban centres, with the possible exception of Kingston and London, do not have nearly enough psychiatrists either.

If we can assume that approximately half of the services of Toronto's psychiatrists are devoted to the care and treatment of hospitalized psychiatric patients, teaching, research and administration, the effective front-line diagnostic and treatment resources for ambulatory psychiatric disorders, which form by far the largest groups of mental illnesses, is no more than ninety to 100 psychiatrists. Thus the effective ratio of psychiatrist to population for the assessment and treatment of psychoneurotic disorders via clinics and private practice is not 1:11,450 but roughly 1:23,000.

Now in Part One, the need expressed in demand for psychiatric service was somewhat arbitrarily postulated to be 10 per cent of the population. Let us further assume, on the basis of the studies cited above, that about 30 per cent

of the resulting 2,300 persons (10 per cent of our ratio) will be in need of the type of treatment provided by hospitals and custodial care institutions and will be served by the physicians employed by the Department of Health on a full and part-time basis. There will remain approximately 1,600 persons in need of the service of each psychiatrist in private practice and in community mental health clinics. There are two aspects to these services: diagnostic consultations, with a view to determining what type of treatment program would be most beneficial; and treatment. Neither of these services can be supplied adequately to the persons needing them by the number of psychiatrists now available in most areas.

The nature of the disorders that we are considering here fall within the range of psychoneurosis and character and behaviour disorders. These are the disorders that respond to psychological treatment. Such treatment is time-consuming and involves the establishment of a therapeutic relationship between the individual and the therapist, usually over a period of time ranging from three months to two years or even more. Consequently, there are definite limits to the number of patients to whom a psychiatrist can offer consultations and treatment during the period of a year. Patient loads vary considerably, depending upon the severity of the problem and the intensity of the treatment in proportion to the frequency of the psychotherapy sessions. But if a psychiatrist were treating patients on the basis of one psychotherapy session per week for each patient, he could carry forty patients, assuming that he can devote forty hours per week to psychotherapy. By adding some hours in the evening and on Saturdays, he could also provide a few consultations to private patients referred by other physicians, or to a clinic. Assuming that the average duration of treatment is three months, it would follow that a psychiatrist could treat no more than 160 patients per year by means of short-term medium-intensity psychotherapy (we have not granted a vacation to our hypothetical psychiatrist!) and provide approximately 240 consultations.

This projection is entirely hypothetical, but it is not unreasonable if we are assuming a young, energetic, well-organized psychiatrist who is able to work a fifty to sixty-hour week (see Table 4.2). Nevertheless, even a *liberal* estimate of consultation and treatment resources combined with a *conservative* estimate of need results in a gross disparity between available resources and need, even in an area such as Metro Toronto, which in comparison with other regions of the province is unusually well supplied with psychiatrists.

Some of the human reality that underlies these figures is dramatically tragic and is the stuff of news stories, such as the recent report of the suburban housewife who, while on a waiting list for psychiatric attention, murdered four of her children. But more typical is the woman who watches her family disintegrate from behind her neurotic defences, the executive who uses his position to act out aggression against dependent employees and his own ulcerated stomach, or the workman who is chronically accident prone — a nuisance to himself, his

employers, the doctors who repair him, and the Workmen's Compensation Board, which foots the bill for his injury and loss of earnings.

Evidently by far the greatest single reason for the inadequacy of psychiatric services in almost all parts of Ontario is the shortage of psychiatrists. Psychiatry, like other branches of medicine, is not able to work miracles; but health benefits that could be available to the public, given the present state of psychiatric knowledge and therapy, are not available simply because we do not have nearly enough trained practitioners.

Adequacy of Psychiatric Training in Meeting Needs

The data concerning the prevalence of mental illness considered in Part One combined with the diagnostic data in this chapter (Tables 4.5, 4.6, 4.7) establish that there is a substantial unserved need for diagnosis and treatment of mental illness in Ontario; and that the greater part of this unserved need is psychoneurosis. Consequently, the paramount social need is for therapists who are qualified to diagnose and treat psychoneurotic disturbances and to a lesser extent the milder forms of character and behavioural disorders. The dominance of "Ontario Hospital Psychiatry" over the training of psychiatrists in the past has arrested the growth of training programs in psychoanalysis, psychodynamics and psychotherapy, which is just the training needed for the successful treatment of psychoneurosis and character and behaviour disorders. That psychotherapy is the treatment of preference for these illnesses, as far as most psychiatrists are concerned, is indicated by the frequency with which it is used, even by psychiatrists who were trained in the Ontario system prior to its reform less than ten years ago (Table 4.9). A further strengthening of the psychodynamic components of psychiatric training would make psychiatric training more adequate to meet mental health needs.

A second, but not secondary, aspect of this problem is the necessity of strengthening the psychodynamic and subspecialty components of psychiatric

TABLE 4.18
Distribution of Subspecialty Interests Among Psychiatrists

Subspecialty	A major interest		Not a major interest		No response	
	No.	%	No.	%	No.	%
General psychiatry	123	82.6	11	7.4	15	10.1
Child psychiatry	51	34.2	55	36.9	43	28.9
Community psychiatry	82	55.0	28	18.8	39	26.2
Family psychiatry	86	57.7	25	16.8	38	25.5
Adolescent psychiatry	79	53.0	29	19.5	41	27.5
Education and training	84	56.4	26	17.5	39	26.2

SOURCE: C. Hanly and D. McGowan, *Mental Health Survey: Psychiatrists (Study 2)*. 1967.
Based on a questionnaire survey of Ontario psychiatrists.

training in order to attract and retain psychiatrists. In the past, physiologically oriented hospital and general psychiatry has been dominant. The force behind this tradition has been the long-standing social demand for facilities, at first for custodial care and more recently for the care and treatment of severely impaired or dangerous persons suffering from psychosis or character and behaviour disorders.

Since the Second World War there has been an acceleration of demand for psychiatrists who can treat milder forms of mental illness, such as emotional disturbances in children, problems of maturation in adolescents and young adults, marital problems — a wide range of developmental problems and neurotic illnesses. New subspecialties are now being developed to serve these needs. Table 4.18 charts the current distribution of interest in general psychiatry as compared with subspecialties.

Education and training is not a subspecialty, but it is a specialized service; like any other it requires aptitude and interest, and improves with experience. It is included in the table for purposes of comparison. The great majority of psychiatrists see themselves as first and foremost interested in general psychiatry. But many also concentrate a major interest in one of the subspecialties. Among these family psychiatry has a slight lead on community and adolescent psychiatry. The development of these subspecialties is important because they involve two things: 1) the perfection of specialized skills for treating developmental problems and the problems of the basic social unit, the family; 2) the prevention of more serious adult illnesses through detection and treatment at an early stage.

A process closely related to the development of new specialties is the growth of specialists in the utilization of certain specific therapeutic techniques such as psychotherapy. These new therapeutic and specialty groupings are represented within the Ontario Psychiatric Association by means of special divisions, such as the Psychotherapy Division.

Any steps that will strengthen these developments should be taken, for at issue is the province's capacity to attract and retain some of its most promising graduates, as Powles' study has shown.⁴ And the solution of the manpower problem is the key to removing inadequacies in current services.

The failure of Ontario's rural communities to compete successfully with urban communities for psychiatrists has already been detailed. But Ontario as a whole is a participant in national and international competition for psychiatrists. An effort was made to determine the extent of Ontario's losses to, and gains from, other provinces but no records were found from which meaningful figures could be derived. Ontario has recently managed a coup by attracting Dr. Epstein and some of his associates from Quebec to the Department of Psychiatry in the new medical school in McMaster University. The province has the advantage of being

⁴W. E. Powles, *op. cit.*

the wealthiest in the competition for psychiatrists trained at the expense of other provinces, and is in the best position to retain its own graduates. Additionally, it appears from the McKerracher Report that, with the exception of a metropolitan area like Montreal, Ontario has one of the oldest and most developed, although perhaps not the most advanced, psychiatric services in Canada.⁵ Moreover, the province is able to attract psychiatrists from the United Kingdom. Among the respondents to the questionnaire to psychiatrists, there were more who had received their medical education in the United Kingdom than from any single Ontario university with the sole exception of the University of Toronto.

TABLE 4.19
Medical Schools Attended by Ontario Psychiatrists

Medical school	No. of graduates	
	No.	%
University of Toronto	62	41.3
University of Western Ontario	18	12.0
Queen's University	15	10.0
Ottawa University	1	0.7
Other Canadian universities	10	6.7
British universities	24	16.0
European universities	15	10.0
American universities	0	0
Other universities	2	1.3
No response	3	2.0
Total	150	100.0

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists* (Study 2), 1967.
Based on a questionnaire survey of Ontario psychiatrists.

Furthermore, rural mental hospitals such as the one located at Goderich and outlying general hospitals such as Sudbury General, which have been generally unsuccessful in attracting Ontario-trained psychiatrists, have had some success in attracting British psychiatrists. Unfortunately, they have had more success in attracting than in retaining them after the initial contract has expired; for once the British psychiatrist has received his Ontario licence, intraprovincial competition takes over to the detriment of rural and outlying municipalities.

Our balance of trade in psychiatrists with the United States, however, is quite another matter. In this respect psychiatry is subject to the same forces that operate in other fields, such as psychology and science generally. Many of Canada's most brilliant graduates who are in a position to compete with American graduates for places in the best postgraduate schools in the States elect to take

D. G. McKerracher, *Trends in Psychiatric Care*, Queen's Printer, Ottawa, 1964, p. 89.

their training there. At this time they often form important professional associations and are offered attractive opportunities for well-remunerated work, both of which they are reluctant to give up in order to return to Ontario to work.

Consequently, there is a brain drain to the U.S. in young physicians who have elected to become psychiatrists. An American study of a dozen states which have highly developed psychiatric services has shown that Canadians form the largest single group of foreigners in psychiatric practice in these states. Undoubtedly one very important factor in this situation has been the superiority of training programs in psychiatry in the major American centres as compared with Ontario, where improvements have been slow and late. There is an obvious way to correct this situation: by providing more rapid improvements in Canadian postgraduate training programs in psychiatry.

A relatively large number of graduates of European medical schools also appear (about 10 per cent), indicating that Ontario has benefited from the political, social and economic difficulties which Europe has suffered in this century. With the renewal and resurgence of all aspects of European life, it is unlikely that we will be able to rely in the future on this supply, and Ontario's training facilities will have to fill the vacuum that will be left.

If this analysis is sound, then a temporary shift in functional priorities from service to teaching could result in a more rapid increase than expected in the number of psychiatrists available for front-line therapeutic service. This increase would result from an improvement in our competitive position vis-à-vis the United States for the services of our own gifted young physicians who have chosen psychiatry as a career. But clearly of equal importance are opportunities for private practice and rewarding work in hospital practice. Anything that can be done to make work more professionally rewarding in our general and mental hospitals also is highly desirable.

The responsibility for training psychiatrists lies with the Departments of Psychiatry in Ontario's five university medical schools (Ottawa, Western, Queen's, Toronto and McMaster) and the teaching hospitals in which psychiatric candidates take their residency. Steps have already been taken to improve the training of psychiatrists in three ways: 1) by increasing the number of years of training required from two to four; 2) by increasing the psychodynamic theoretical and practical content with the inclusion of supervised psychotherapy control cases; 3) by requiring that at least two of the four years be spent under the immediate direction of a medical school.

The theoretical and pedagogical basis of all of the province's Departments of Psychiatry is eclecticism. In a discipline that must encompass an understanding of phenomena as diverse as the physiology of the nervous system and the cathartic effects of classical tragedy, eclecticism is inevitable and necessary. However,

eclecticism is a programming strategy and not itself a valid theoretical orientation. Further, in itself, eclecticism does not provide for a valid ordering of priorities among various distinct bodies of knowledge and treatment procedures. In the past, the eclecticism of Ontario's Departments of Psychiatry, in contrast with McGill, Harvard, Columbia, Yale and other top American schools, has fallen short of benefiting fully from psychoanalysis and psychotherapy.

The University of Western Ontario graduate training program in psychiatry is oriented largely around hospital work, which, of course, includes outpatient clinic experience; but supervised psychotherapy control cases are not mentioned specifically in the syllabus.

Year one is spent in one of the mental hospital services at the Ontario Hospital in London or St. Thomas. Years two and three involve four six-month rotations through the psychiatric services at Victoria Hospital, Westminster Hospital, St. Joseph's Hospital and Children's Psychiatric Research Institute. Year four is left unassigned but may include a return to one of the general hospital wards as resident to gain experience not included in the standard rotation, such as the treatment of alcoholics.

In contrast, the McMaster program involves, along with the complete range of hospital experience, comprehensive training in psychodynamic psychiatry directly planned and organized by the Department of Psychiatry. It is described in the syllabus as follows:

The training candidate receives regularly scheduled, intensive, weekly supervision in the techniques of psychotherapy. This includes separate supervision for each of three areas of therapy technique: individual, group, and family. In addition, all residents may obtain supervision in play therapy with children at some time during their four year program. There are separate sessions for each of these types of therapy with different supervisors. Both the supervisors and the cases used in this aspect of the training program are drawn from the central resources of the McMaster Department of Psychiatry. This means that the patients used for the supervision can come from any of the clinical sources via a central registry and that the resident consequently has available to him a number of patients from whom appropriate ones can be chosen. It also means that the resident is exposed to techniques, views, and personalities from a wider clinical base. This part of the program is conducted separately from the "clinical" part in order to make optimal use of the supervisory resources. A number of techniques are utilized in the supervision sessions. The Department is amply equipped with stereophonic tape recorders, closed circuit television and video tape equipment, and one-way screens. The techniques of instruction are being studied and up-dated constantly. There are manifold reasons underlying the elaborate formal organization in this area. We wish to avoid having the "intuitive" and "artistic" aspects of psychotherapy procedures become the precursors of imprecision and casual conceptualization. The basically interpersonal nature of the instruction ought not to promote anecdotal or impressionistic case descriptions. Since this type of supervision is the truly unique element of a good psychiatry training pro-

gram, it should never take second place in a resident's scheme due to service demands. The supervisory program resembles its clinical counterpart in that the intensity of supervision decreases with the experience of a resident. An exception to this would be in the case of a resident opting for extra exposure in a chosen field of specialization.

An example of the above system is the group therapy supervision program, in which there are 4 elements:

- (a) didactic sessions
- (b) sensitivity-experience group
- (c) group therapy and supervision
- (d) colloquia

The didactic sessions, designed to familiarize and orient the candidates to the concepts and literature in the field, cover experimental-theoretical considerations, transactional theory and psychoanalytic theory in order. They interdigitate with the 12-session residents' group, conducted by one of our staff, which in turn is replaced by therapy and supervision. These latter take place after the initiate has some of the tools necessary to make use of them. In succeeding years the group supervision takes place without the proceeding elements, and becomes less intense. The colloquia are quarterly meetings of all supervisors and residents in a supervisory section to share and discuss theoretical, clinical, and methodological matters that grow out of their activities. All these activities are phased so as to consume a fairly constant amount of time from the resident's schedule through the year.

The Department of Psychiatry of McMaster is a significant development. All members of the mental health professions who are aware of the plans of the department seem enthusiastic and optimistic about them. The program will add to the number of psychiatrists trained and, even more important, it is likely to improve the quality of training.

Contrary to what one might expect, improvements in the quality and standards of psychiatric training will increase the attractiveness of psychiatry to medical students. One of the reasons that medical students of high calibre who have been interested in psychiatry have opted for some other specialty has been their impression that the practice of psychiatry is not based on a coherent, well-established body of knowledge accompanied by specific acquirable technical skills and therapeutic procedures. The prospect of a career devoted to the custodial management of chronic mental patients in Ontario Hospitals does not enhance their enthusiasm. For this reason alone, it is essential that the university departments should be given every assistance to improve the quality of instruction and should retain supervision of all postgraduate training, including the hospital residency.

In the past the Ontario Hospitals have succumbed to the temptation to use their psychiatric residents to provide service, rather than provide them with well-designed and supervised learning and training experiences. This practice has been and, insofar as it still exists, remains detrimental to the development of psychiatry in Ontario. It can be effectively discouraged by giving the university departments complete authority over all aspects of the training of psychiatrists

including their residency in hospital settings. A simple method for achieving this would be to have the Royal College of Physicians and Surgeons require that candidates for certification examinations hold a Diploma in Psychiatry from an accredited medical school. This procedure could have the additional advantage of establishing a uniform national standard, assuming that Canada's Medical Schools could agree upon common standards for the Diploma in Psychiatry.

At present the regulations of the Royal College require two years of approved resident training, during which the trainee participates in the organized training program of a University Department of Psychiatry.⁶ In addition to the two years of residency directly under university supervision, there is the requirement of two years' training that is not specifically subject to university control.

These additional years may involve:

- i) One or more years of resident training in Psychiatry in an approved mental hospital.
- ii) One or more years of further approved training as outlined under section 2(a), providing such training includes the necessary minimum experience in the treatment of psychotic patients.
- iii) One year of approved resident training in internal Medicine.
- iv) One year in the full-time study of related basic science such as Neuro-anatomy, Neurophysiology, Psychology or Sociology in a Department approved by the College.
- v) Six months of approved full-time study of a related basic science and six months of approved resident training in Internal Medicine, Pediatrics or other branch of medical practice related to Psychiatry.
- vi) One year in an approved course of study and training at a hospital or university centre in Canada or abroad.
- vii) One year in a psychiatric specialty such as Child Psychiatry, Community Psychiatry or Research.⁷

The university departments have made strong and constructive responses to their involvement. The University of Toronto has conducted a two-year post-graduate course in psychiatry leading to a Diploma in Psychiatry, which has now been extended to three years. Under the new program the university department will have a better opportunity to influence significantly the quality and direction of psychiatric education and training.

The Royal College approves certain hospitals for advanced graduate training. Prior to the recent development of psychiatric units in general hospitals, the major hospital training centres were located in Ontario Hospitals. The regulations of the Royal College explicitly favour these settings. The preamble to the statement of training requirements contains the provision that "these two years of training

⁶*Regulations and Requirements of Graduate Training Relating to the Examinations of the Royal College of Physicians and Surgeons of Canada: Medicine and Medical Specialties*, 1966, section 2(a), p. 32.

⁷*Ibid.*, section 2(b), p. 33.

(post-university training) must include at least six months and preferably one year in a hospital providing an opportunity for the study of the comprehensive care of psychotic patients for a sufficiently long period to permit the resident to observe the natural course of the illness and its treatment".⁸ Since in the past and even to the present, the mental hospitals have been the major centres for the treatment of psychotic patients (the general hospitals prefer not to undertake the treatment of psychotic patients, who require long-term treatment and custodial care), the effect of the regulation is to make an Ontario Hospital residency of not less than six months practically mandatory. No one objected to this provision in principle, but numerous objections to it in practice were made during field interviews. They are essentially as follows.

- 1) The Ontario Hospitals, because of their manpower shortage, exploit the residency. The resident too often finds himself administering drugs and providing general practice medical services to a large patient population, with the result that the observation and the study of the "natural course" and "treatment" of psychotic disorders are out of the question.
- 2) Even if the resident has received a comprehensive and solid training in the treatment of psychotic illnesses, he finds that, unless he chooses to make a career of Ontario Hospital practice, these illnesses and the techniques for treating them represent only a marginal component of his psychiatric work. He discovers that he is relatively unprepared for treating neurotic disorders, problems of arrested maturation, motivational and behaviour problems.
- 3) The mental hospital residency, and now the general hospital inpatient residency, has tended to be associated with preparation in general psychiatry. But the treatment of psychosis is itself a specialty, like child psychiatry and community psychiatry. The emphasis placed on mental hospital service in psychiatric training produces psychiatrists who are certified and licensed for private practice in any of the different psychiatric specialties without being adequately trained in them.
- 4) Because of the almost exclusive emphasis placed on chemotherapy, ECT, environmental manipulation, and custodial management in the mental hospitals and inpatient services of general hospitals, there has been a serious impoverishment of the psychodynamic aspects of psychiatry. The use of supervised control cases for teaching psychotherapy became widely adopted in Ontario as recently as seven years ago. This practice has been routine in the

⁸*Ibid.*, p. 32.

better American schools for many years. There is also not sufficient opportunity for intensive subspecialty training, for example, in child psychiatry or community psychiatry.

- 5) Although internal medicine, paediatrics, psychology and sociology are mentioned as legitimate specialist studies for psychiatric residents in the Royal College training requirements, psychoanalysis is not mentioned. Compared with the training provided to psychiatrists at a prominent U.S. medical school such as Columbia University, the omission is striking. In addition to receiving a thorough training in the theory and practice of psychodynamics, every resident in psychiatry was voluntarily undertaking personal psychoanalysis or training analysis. Over 30 per cent of the residents in psychiatry at the Bellevue Hospital in New York were doing the same, although psychoanalysis has not been as influential in the Medical School of New York University and although the Bellevue Hospital is to the Columbia Presbyterian Hospital what the Ontario Hospital at St. Thomas is to the Clarke Institute.
- 6) It has been stated already that training in psychodynamics and psychotherapy has been introduced quite recently in Ontario training programs. Essential to this training is the supervision of control cases by means of which candidates are trained in psychotherapeutic skills. This supervision by a senior psychiatrist provides a natural and important mechanism for identifying any psychopathology in the candidate that might interfere with his therapeutic capacity. According to teachers interviewed, minor disturbances of perceptivity and reactions in psychotherapy can be corrected through the supervision of control cases. Candidates with more serious problems are advised to seek psychotherapy privately. Although this type of procedure is of first importance for the selection and training of psychiatrists, it is by-passed by the regulations of the Royal College.

Four recommendations for change were presented by psychiatrists who voiced these criticisms of current training and examining procedures.

- 1) The new approach to training in psychiatry adopted by Departments of Psychiatry in the medical schools will bring about the necessary corrections. Therefore, the most important single reform would be the extension of control by the university departments over all aspects of training, including the residency in teaching hospitals.
- 2) The psychodynamic and psychotherapeutic content of the curriculum should be further improved and enriched.
- 3) The U.K. and the U.S. have adopted the policy of establishing

subspecialty boards in different areas such as child psychiatry and community psychiatry. Only those who have selected appropriate residential options of the type enumerated in section 2(b) of the Royal College training requirements (see p. 77) and have been related courses of study would be eligible to take the board examinations and become qualified as a specialist in the field. For example, only a certified child psychiatrist could practise child psychiatry. This policy was recommended for adoption in Ontario and in Canada.

- 4) In the final analysis one of the best guarantees of excellence in a profession is the training available to it. It is the only guarantee of the more intangible qualities of excellence beyond competence. It is also very likely that as psychiatric service and training improve in quality, the profession will derive the additional benefit of attracting to it more capable and intelligent medical graduates. From the point of view of the public as well as the profession, this is sufficient reason for supporting any changes that will bring such improvements.

Adequacy of Licensure in Meeting Needs

As stated earlier, a major cause of inadequacy in mental health resources is the lack of sufficient numbers of psychiatrists (Table 4.16). It is against the background of the manpower problem in psychiatry that licensure should be discussed; for it is in part because of the shortage of needed professional services that a public interest in the question arises. In the absence of this shortage the problem would be essentially an intraprofessional one, involving physicians from different training backgrounds. The only major issue (assuming that licensing and regulation are serving their basic purpose of guarding against the quack, the charlatan and the malpractising physician) would be the question of intrajurisdictional equity. There is a *prima facie* case against denying a licence to a physician with an equally good or better training background and possessing a licence from another jurisdiction, and a *prima facie* case, given the basic social purpose of licensing, for some form of screening process and a probationary period. But the power of licensure is also a socio-economic instrument by which a profession is able to monopolize a service, with or without scientific and technological justification, and to use it to control the amount of service available with a view to maintaining artificially high levels of demand for service and correspondingly high financial rewards for dispensing it. It is this fact, combined with the acute shortage of services, that has generated and that justifies public interest in the question of licensure in psychiatry.

Licensure in psychiatry is governed by the same general principles that pertain to all medical specialties. The *licence* is issued by a provincial body, the College of Physicians and Surgeons of Ontario. The issuance of a licence by the College

of Physicians and Surgeons is conditional upon, but not guaranteed by, the acquisition of a certificate which is granted by the Royal College of Physicians and Surgeons of Canada. The Royal College is a national body which conducts Fellowship and Certification examinations in a number of medical and surgical specialties. The acquisition of a Canadian certificate in psychiatry (or in any other specialty) does not guarantee that the certificate holder will be licensed to practise his specialty in Ontario.

Reciprocity of licensure can take two forms: interprovincial (national) or interjurisdictional (international). Although some other provinces have reciprocity of licensure, Ontario does not have such reciprocity with any other province. It is possible that a physician trained in psychiatry in another province and certified by the Royal College as a specialist in psychiatry might be refused an Ontario specialist licence. Such a physician would be able to practise medicine in the province, but he would not be entitled to represent himself as a specialist to his patients, to charge specialist's fees, or to have services insured by OMSIP under the specialists' schedule. The College of Physicians and Surgeons of Ontario has adopted this policy on the grounds that training in some other provinces is inferior to training in Ontario, and that the examinations of the Royal College are not sufficiently stringent to weed out unprepared candidates.

The policy produces some anomalies when it is considered in the context of psychiatric training and service in Ontario. Training in psychiatry in Ontario has been reformed only quite recently. Nevertheless, this study did not uncover any cases of Ontario-trained psychiatrists who have been denied licences to practise on the grounds that they did not receive an adequate training in Ontario. Further, there are physicians practising in Ontario Hospitals who have failed the certificate examinations of the Royal College. The question naturally arises as to whether they are as well prepared for psychiatric practice as psychiatrists trained in other provinces who have passed the Royal College examinations, and whose services Ontario might attract if our licensing policies did not discourage them from coming here.

Neither is there international reciprocity of licensure between Ontario and any non-Canadian jurisdiction. A medical graduate from Ontario may train at an American school of psychiatry approved by the Royal College and then take the Royal College examination, be certified, and apply for an Ontario licence. However, if he were trained in the same way and in the same schools, had taken the American Board examinations, and was certified to practise psychiatry in the U.S., he would also have to take the Royal College examinations in order to obtain a Canadian certificate before he would be eligible to practise his specialty in Ontario. The same applies to American physicians and to Canadian physicians who have received their postgraduate training in the U.K., and to entirely British-trained psychiatrists.

In comparison with physicians trained elsewhere outside Canada, however, British and American certified psychiatrists are placed in an especially favoured position. They are eligible for an Enabling Certificate which entitles them to practise medicine for a two-year probationary period after presenting their documents of training and certification from other jurisdictions to the College of Physicians and Surgeons of Ontario. But by the end of this two-year period they will have to have taken and passed the Medical Council of Canada examinations⁹ and have received their Canadian certificate in order to be eligible for licensing in Ontario. This Enabling Certificate does not allow the British or American psychiatrist to practise psychiatry or to receive a specialist's remuneration for which certification by the Royal College is required.

Only one American medical school, the Irving College of Medicine in California, is blacklisted by the Canadian College. None of its graduates is acceptable on any basis. No British medical school is blacklisted. One Irish school, Apothecaries Hall, is blacklisted. Graduates of all other medical schools in the U.S., the U.K., and Ireland are accepted subject to the conditions already specified. In contrast only specific medical schools in Europe, Asia, the Middle East and elsewhere are included in lists of acceptable institutions. Additionally, even with a postgraduate degree and foreign certification in psychiatry, postgraduates are required:

- 1) To take examinations set by the Educational Council for Foreign Medical Graduates.
- 2) To undergo a two-year internship — one year of rotation and one year of straight internship (which may be psychiatry) during which time they will take basic science examinations.
- 3) To take the Medical Council Examinations, success in which will make them eligible for certification as general practitioners by the Ontario College of Physicians and Surgeons and entitle them to a licence to practise medicine.
- 4) To meet whatever additional requirements the Royal College of Physicians and Surgeons may lay down as training prerequisites before they are admitted to the examinations for certification in psychiatry.

The system is well calculated to screen out any incompetent, poorly prepared physicians who, having failed to establish a practice in their own country, have decided to try their luck elsewhere. But it has some disadvantages as well, and the question arises as to whether a screen with somewhat larger interstices might not retain the principal advantage for society without the disadvantages of the present system.

⁹The Medical Council of Canada conducts examinations for registration of medical practitioners on behalf of the College of Physicians and Surgeons of Ontario.

What are some of the disadvantages? It has already been stated that there do not appear to be large numbers of American, European or other foreign psychiatrists clamoring for an opportunity to come to Ontario to practise. Nevertheless, other professions in Ontario (university teachers, for example) are strengthened by the recruitment of foreign-born and/or foreign-educated professionals who, for a variety of perfectly sound reasons, have become interested in a career in Ontario. It is likely that the special requirements for Europeans and other foreign psychiatrists, and also the lighter requirements for American and British psychiatrists, act as an effective deterrent against the best or even the average, in the absence of very special inducements such as a much higher salary, better work opportunities, or compelling personal reasons.¹⁰ The difference in Ontario's salaries for psychiatrists as compared with Britain's has been able to provide that special inducement to a number of British psychiatrists, but this factor is inoperative as far as Americans are concerned.

The worst effect of the system is that it deters Canadian-born and trained physicians who have trained in psychiatry in U.S. medical schools from returning to Ontario. The psychiatrists in W. E. Powles' survey cited "the necessity to take an additional year of training in Canada before being eligible for certification, and the hurdles or barriers of licensure and certification examinations" as barriers to their return to Canada.¹¹ Yet these physicians are precisely those whom Ontario most needs.

The Department of Health has been, is, and will be in need of foreign psychiatrists to fill vacancies in the mental hospitals. Although it has not been unsuccessful in the past, it might be more successful in raiding other jurisdictions for experienced and highly skilled psychiatrists if there were some form of reciprocity. This, at least, is the opinion of foreign-trained psychiatrists working in Ontario Hospitals who were interviewed. These physicians thought that a probationary period of one year should be sufficient for graduates of accredited medical schools in other jurisdictions who have been certified in the jurisdiction of their training.

In addition to their undesirable effects on the manpower problem, the existing regulations create three anomalous situations. First, there is the Canadian-born physician practising in Ontario, who has received postgraduate training in the best medical schools in the U.S. and is a certified psychiatric specialist in the U.S., but who is licensed in Ontario only to practise medicine and whose specialist services are insured by OMSIP only at general practitioners' rates. Second, there is the Canadian-trained psychiatrist who is certified by the Royal College, licensed to practise his specialty in another Canadian province, but unable to obtain a licence to practise in Ontario. And third, there is the physician

¹⁰This assumption has been validated for Canadian physicians trained and certified to practise psychiatry in the U.S. by the study conducted by W. E. Powles, *op. cit.*

¹¹*Ibid.*

who has completed his psychiatric training, has failed the Royal College examinations, and is nevertheless employed to perform the tasks of a psychiatrist in the Ontario Hospitals. This last anomaly underlines the fact that, as far as high quality psychiatric services are concerned, Ontario is in fact a poor cousin relative to other jurisdictions of comparable socio-economic and scientific advancement, although it claims to be both rich in these resources and a leader in the field.

The Ontario Psychiatric Association's Brief to the Committee on the Healing Arts takes the view that it is within the competence of the Royal College to rectify the situation.¹² At present different standards of psychiatric training and licensure exist in the different provinces of Canada. If the Royal College were to adopt as its standard the highest provincial standard, and were to refuse to certify anyone from any province who did not meet it, then anyone holding a Canadian certificate could expect to be licensed in any province, including Ontario.

This remedy has a minor and a major flaw. Its minor flaw is that temporarily it will aggravate the recruitment problem. In the long run, however, if highly capable people are to be attracted to psychiatry, demanding standards must be set. The major flaw of the proposal is that its implementation would remove only one of the three anomalies cited above. What is needed is a solution to the first and second situations that will also solve the third — that is, a solution that will improve Ontario's capacity to attract the best trained and most capable psychiatrists so as to free the Ontario Hospitals from having to hire physicians who have actually failed to demonstrate their competence in psychiatry.

Despite real differences the practice of the international academic and scientific community may serve as a model for change. University postgraduate training programs are related informally. The ratings change with changes in the programs and the professors at the universities. Depending on the rating of the university and on his own individual qualities and standing, the person in training will receive either a permanent or a probationary appointment at a university or research institute. The nationality of the university is deemed to be irrelevant. As indicated above, there is already a rather similar formal evaluation of postgraduate training programs in psychiatry in other jurisdictions and by Ontario College of Physicians and by the Royal College, for the purpose of directing Canadian medical graduates to suitable training centres. These evaluations presumably are made on the basis of curriculum, supervision of residential practice, duration of program, and the quality of instruction. Any graduate of such an approved program could be licensed to practise psychiatry in Ontario on the basis of his certification either by the Royal College or by the appropriate body in the jurisdiction in which he was trained. Thus, a graduate of the Menninger Clinic, or of the Harvard, Columbia or Yale Medical School postgraduate programs in psychiatry who had taken American Board examinations, would

¹²Ontario Psychiatric Association, Brief to the Committee on the Healing Arts, 1967, p. 10.

be equally eligible with graduates of Ontario's medical schools for a licence to practise his specialty. Reason dictates that this should be the case. Similarly, the graduate of *any* medical school in *any* country that meets the standard established by the province would have the same eligibility.

A number of advantages would derive from this system. The Ontario physician who had taken his specialty training abroad, as many of the best are inclined to do, and who had elected to be certified in the jurisdiction of his training, would cease to be deterred from returning to Ontario to practise his specialty by the inconvenience of a second set of examinations. This would rectify the first anomaly. It might rectify the third anomaly also, by attracting more psychiatrists to the province.

This proposal meets the principal objection to simple reciprocity, that there are substantial differences among the training programs leading to certification in other provinces of Canada and in other countries, such as the United Kingdom. Graduates of substantially inferior programs would not object to meeting the requirements of acquiring a Canadian certificate. But under the present system, graduates of superior programs can legitimately complain against the inconvenience of additional examinations and, in the case of Europeans, additional training. After all, the only valid basis for licensing in psychiatry or any similar discipline is the quantity and quality of training in psychiatric science, its technology and its applications, and demonstrated ability as a therapist. Therefore, licensure should be based on the recognition of medical schools and training programs whatever the jurisdiction in which they are located, rather than on the practices of other licensing bodies. Such a principle is already employed in a limited way by the Royal College and the Ontario College. Consequently, the suggested modification involves only an extension of existing principles and practices. It also meets the legitimate objections to *carte blanche* reciprocity with another jurisdiction, such as the United Kingdom, which may license psychiatrists with inadequate as well as adequate and superior training backgrounds as evaluated by Ontario's training standards.

The essence of the suggested modification is simply this:

- 1) The Ontario College of Physicians and Surgeons should establish a list of medical schools and training programs in psychiatry located in other jurisdictions (without socio-cultural or linguistic bias), successful completion of which would entitle the graduate to a probationary licence to practise his specialty in Ontario for two years.
- 2) On expiry of the probationary licence, the individual would become eligible for a permanent licence, unless cause had been shown as to why it should not be granted, in which case the individual would have the right to call for an examination of his knowledge and capabilities by a panel of examiners.

This modification is within the competence of the Ontario College of Physicians and Surgeons. It would not involve reciprocity with any other jurisdiction. It could be carried out unilaterally.

It may, however, generate a schism between the Royal College and the Ontario College, unless the Royal College were prepared to grant a Canadian certificate to psychiatrists admitted to practice in Ontario under such modified regulations.

Adequacy of Psychiatric Services in Meeting Needs

Although the Ontario Hospitals leave much room for improvement, when supported — as they now are — by the psychiatric wards of general hospitals, they are quantitatively adequate. What is of first importance is the strengthening of non-hospital services: private and group practice, and community clinics. Growth in these sectors will reduce the need for hospitalization and the additional expenses involved for the patient and the public. Experiments in the provision of psychiatric services, such as those of Service Three in New Haven, Connecticut, suggest that a well-run community mental health service can identify and treat very severe illnesses without hospitalization.¹³ The Saskatchewan experience points in the same direction.¹⁴

Growth in the range of psychiatric services is reflected by the increase in the number of psychiatrists in private practice, community clinics, and special services such as centres for emotionally disturbed children, forensic clinics and schools. Most psychiatrists engage in at least three of the four predominant functions of psychiatrists: hospital practice, private practice, teaching and research, and administration. The result is the complex work pattern shown in Table 4.20. The important features of the pattern can be perceived by making horizontal and vertical comparisons. More psychiatrists do part-time and full-time clinical work than do part-time and full-time private practice. But the number giving percentage amounts of part time or full time to private practice is beginning to draw equal to the number in clinical practice.

Probably private will soon outweigh clinical practice. There are a number of reasons for this. Hospital services are used, for the most part, for the treatment of psychotic illnesses. The number of these illnesses remains fairly constant as a percentage of population and hospital facilities to treat them are relatively well developed. The percentage of psychotic illnesses to all mental illnesses is low. It is into this sector of mental health that most resources have gone in the past.

Private practice is best suited to the treatment of psychoneurotic illnesses.

¹³Interview with M. Pepper, M.D., Director, Service Three, New Haven, Connecticut, Summer 1967.

¹⁴See F. S. Lawson, "The Saskatchewan Plan", Report to the Eighth Mental Hospital Institute in Denver, Colorado and F. S. Lawson, "Mental Hospitals: Their Size and Function", *Canadian Journal of Psychiatric Hospitals*, Vol. 49, 1958, pp. 192-195.

TABLE 4.20
Distribution of Work of Psychiatrists Among Private Practice, Clinical Practice, Teaching and Research, and Administration

Nature of activity	Percentage of time per week								Total psychiatrists giving some time	Total psychiatrists giving no time to activity
	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-	
Clinical practice	16	15	10	15	17	5	3	8	25	35
Private practice	30	13	8	6	14	2	7	3	20	46
Teaching and research	35	20	4	12	5	1	3	2	7	60
Administration	48	23	11	10	6	3	—	1	1	46

SOURCE: C. Hanly and W. Christian, Mental Health Survey: Psychiatrists (Study 2), 1967. Based on a questionnaire survey of Ontario psychiatrists.

The percentage of these in relation to all mental illnesses is high (78 per cent of the diagnoses reported by psychiatrists in Study 1 for this report were psychoneuroses). The remaining 22 per cent were composed of psychoses, character and behaviour disorders, alcoholism, brain damage, and other disorders (Table 4.5). (Since some psychotic patients are taken directly to mental hospitals where they are seen by psychiatrists in the employ of the Department of Health, these figures could perhaps be corrected to 70 per cent and 30 per cent respectively, to give reasonable approximations.) With the introduction of OMSIP's coverage of treatment for psychiatric services, more persons will be seeking treatment for psychoneurotic disorders under the conditions offered by private practice, thus exerting increasing pressure for expansion in this sector.

One problem that has been identified in this study — the unequal distribution of psychiatrists throughout the province — will not be solved by natural growth but will require special planning. In the section on services, we will outline our suggestions in this regard.

As the range of practice opportunities increases in Ontario, there should be a highly desirable long-term effect. One of the reasons cited by Canadian physicians for their decision to practise psychiatry in the U.S. is the greater range of practice opportunities there.¹⁵ The direction of growth in psychiatry in Ontario will tend to improve Ontario's competitive position vis-à-vis the United States. Although in the short run it may appear that the trend towards subspecialties, private practice and specialized services such as school mental health programs will further aggravate the recruitment problems of the mental hospitals and general hospitals, the trend should be advantageous for all services in the long run.

A special aspect of the adequacy of psychiatric services in meeting mental health needs concerns the teaching and research functions of psychiatrists. Our study has indicated a widespread interest in teaching among psychiatrists in Ontario (Table 4.4). This interest expresses itself in the commitment to teaching reflected in Table 4.21.

The table shows that of the 149 psychiatrists in the sample, 103 do some

TABLE 4.21
Teaching Commitments of Ontario Psychiatrists

Number of psychiatrists	Hours of teaching per week as a percentage of total work load								
	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-
	48	23	11	10	6	3	—	1	1

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
Based on a questionnaire survey of Ontario psychiatrists.

¹⁵W. E. Powles, *op. cit.*

teaching, although most teach relatively few hours per week. Clearly a great many of Ontario's psychiatrists have some teaching experience. Of the 110 respondents who completed the section on major interests, eighty-four identified education and training as one of their major interests (Table 4.4). Asked to which, if any, activities in psychiatry they would like to devote more time, sixty-three indicated a wish to be able to devote more time to education and research. The interest and experience needed to expand training facilities evidently exist; they require only effective organization. Given the magnitude of the requirement for more psychiatrists, it would appear that the best alternative is to assign more trained psychiatrists to teaching in expanded training programs, and to accept a temporary increase in the waiting lists of private practices and outpatient clinics.

Several spontaneous in-service training programs have been developed by individual psychiatrists to try to meet the needs of the service in which they work. These will be discussed at greater length in other contexts, but we will mention four of them here. While he was Director of the Forensic Clinic in Toronto P. G. Thomson initiated an in-service training program in group psychotherapy for psychologists and social workers in the clinic; D. J. McCulloch initiated a case-seminar teaching program for general practitioners on a province-wide basis; M. A. Fischer has conducted group therapy sessions for child care workers employed by John Brown Camps; J. D. Atcheson has undertaken a two-year training program for child care workers at Thistletown.

Certain features of these programs deserve comment.

- 1) They demonstrate again the willingness of individual psychiatrists to try to meet the challenge of mental health needs in the province in a wide variety of settings and ways.
- 2) Except in the case of Dr. Atcheson's program they have neither a stable institutional base nor public support. Consequently, they rely on special individual initiatives. This circumstance has the great advantage of spontaneity, freedom from bureaucratic restrictions, and close proximity to the situation, its problems and demands; but it has the disadvantage that the programs flounder and disappear when the individual who has given them leadership moves on.
- 3) Not only are psychiatrists needed to train other psychiatrists, but they are also needed to train other mental health professionals and workers, thus adding to the drain on teaching resources.
- 4) Although Dr. Atcheson's program has a sound institutional base, it has encountered the dilemma of training vs. service. In order to advance the training program, it will be necessary to cut back on the services offered by the Thistletown Hospital where the program is located; and in order to maintain services at their present level, it will be necessary to cut back on the training program which

adds to manpower shortages. That is a dilemma that psychiatry will have to face many times in many different settings in the province the next decade.

One can legitimately ask how medicine has permitted itself to get into this dilemma. It is not the only profession that has faced a manpower problem since the Second World War. Engineering has faced, and has already solved, a problem of similar proportions. Engineering faculties at universities responded quickly, energetically, and, in the case of the new faculty at the University of Waterloo, imaginatively, to society's need for more engineers. A comparison of admissions to and graduations from engineering and medicine over the postwar period demonstrates the difference.

What is the explanation? Do engineers have a stronger sense of social responsibility? Do engineers have a higher level of social awareness? Has government been generous with engineering faculties and assisted their expansion, while being niggardly with medical faculties and resisting their expansion? Whatever the answers to these questions may be — and they can hardly be simple — in the current manpower problem in psychiatry a strong argument can be found for having some representation of the public interest on bodies that control the education and licensing of psychiatrists.

Psychiatrists are, of course, fully aware of the manpower problems, as shown in the brief of the Ontario Psychiatric Association to the Committee on the Healing Arts. One solution has been advocated recently by D. B. Coates, a community psychiatrist. Basing his reasoning on estimates of need that approximate those in Part One of this study, Dr. Coates advocates that the services of psychiatrists, and of the other mental health professions as well, be restricted to the treatment of only the most severely ill and handicapped patients. A relatively small number of community psychiatrists might be expected, so that they might undertake to teach clergymen, physicians, probation officers, teachers and others how to assist neurotic people through periods of crisis.

The acute shortage of professionals to serve the severely ill is well known, yet I believe that if psychiatrists, social workers and psychologists would restrict their efforts to serving this limited but severely handicapped group, much more could be done to meet the urgent needs of this group.

However, in considering the needs of those with mental health problems — remembering that these number one person in every four — then it becomes blatantly impossible for professional care ever to be relevant to a problem of such magnitude, assuming it to be provided by mental health professionals. Yet, by broadening the coverage of those with healing skills — teachers, clergy, physicians, probation officers, etc. — this larger group might well be helped through most of their crises, and possibly helped in such a way that they would be better able to handle future crises.¹⁶

¹⁶D. B. Coates, "Poverty and Mental Health", *Canada's Mental Health*, Vol. XV, No's 5 and 6, p. 4.

Other psychiatrists, however, while sharing the same perception of the scope of the problem and agreeing with the importance of improving mental health services at the community level, remain unconvinced about the method. The proposal calls for an increase in hospital and community clinic psychiatrists at the expense of private practice, with its expensive one-to-one relationship between patient and physician. This suggestion is not likely to be very attractive to psychiatrists who find that they are providing an essential health service through their private practices, or to patients who prefer to be treated on this basis.

The proposal also calls for the "training" of persons such as teachers, police, clergymen, to help people through periods of depression, suicidal impulses, irrational acting out of infantile fantasies, and so on, and to help them in such a way that they will be able to resolve these difficulties and handle any recurrences independently. This author is not competent to evaluate the capabilities of police, clergymen, teachers and others to perform on-the-spot psychotherapy. But surely the amount of training that would be needed to make these persons competent as mental health counsellors or therapists would be considerable, while the time available to them for utilizing such additional training would be very marginal. If the natural concern some persons have for those who are suffering from a mental illness were therapeutic, the need for community psychiatry would never have arisen.

These criticisms are intended, not to question community psychiatry as such, but to point out the unreality of the expectation that psychiatry can expect much substantive help from professional and subprofessional groups outside the mental health field. Better coordination of psychiatry with other mental health professions is much more likely to be effective.

The problem of resources still exists, however. Even without the special educational efforts by community psychiatrists to improve the level of general understanding of mental illness and health, there will be increasing demands for professional expert treatment services by an increasingly sophisticated public. Community psychiatry will only accelerate the process. Therefore, to build an effective program of community psychiatry a method must be found for increasing the number of *trained* psychological therapists, whether or not they are psychiatrists. We are thus brought to one of the basic questions of this section: can part of the work of a psychiatrist be performed successfully by an appropriately trained non-psychiatrist, such as a clinical psychologist or a psychiatric social worker?

Competence of Other Mental Health Professionals

It has been shown that psychoneurosis is the most common type of mental illness treated by psychiatrists in Ontario (Tables 4.5, 4.6, 4.7). According to the studies cited in Part One, this result was to be expected. Furthermore, as mental health services expand, the percentage of psychoneuroses will increase as a fraction of

all treated illnesses, because they form by far the largest part of currently untreated illnesses. It has been shown also that a uniquely psychological mode of treatment — individual psychotherapy — which does not involve the strictly medical procedure of a physical examination or the prescription of drugs, is the major single form of treatment in psychiatry (Tables 4.8, 4.9). This is not surprising, because it reflects the fact that psychoneurotic illnesses are psychogenetic. To repeat part of the quotation from Leighton's etiological differentiation of the basic types of mental illness, "Psychological experience (is) *predominant in* (the causation of) psychoneurosis and psychophysiological disorders." Now if the treatment of psychoneurosis forms the bulk of the private practice of psychiatrists, if the disorder itself is psychogenetic, and if the method of treatment is psychological (psychotherapy), then part of the need for more private practitioners could, *in principle*, be met by psychologists with a thorough training in psychotherapy. In that case, why are there scarcely any non-medical psychotherapists in private practice, and in community or outpatient clinics? Why have psychiatrists not actively encouraged this development in mental health resources?

There are two theoretical objections: 1) an initial diagnosis to eliminate organic determinants is required, and this can be performed only by a medical doctor; 2) any concomitant physical condition associated with a mental illness must be treated by a medical doctor. Both of these problems are real. The Stirling County Study disclosed a definite association between mental ill health and physical ill health. The Heyfield Study found that 12.2 per cent of the persons suffering from some degree of psychiatric disability had an associated physical disorder. However, no one has claimed that in order to treat the psychiatric illness the physical disorder must always be treated also and by the same person. Indeed, as we shall see in subsequent discussions, just the opposite is the case.

It has been indicated that the physical examination of a patient and his treatment for a physical disorder are not conducted by his psychiatrist in the course of psychotherapeutic treatment. Consequently, when the Ontario Psychiatric Association states that psychiatrists alone among the mental health professions have the requisite knowledge and legal privilege of undertaking a physical examination of a patient,¹⁷ it is stating an obvious truth, but a truth the importance of which can easily be exaggerated when taken out of context. In our field interviews, psychiatrists with an active private practice in the psychotherapeutic treatment of psychoneurotic patients stated that they never perform physical examinations of patients or treat an associated physical illness. A psychiatrist admitting an emergency case to hospital who is going to be receiving drugs and no psychotherapy from the doctor in question is in a very different position with respect to conducting a physical examination of a patient. Thus the role of medicine in psychiatry is different in private practice, a community clinic, or an

¹⁷Hearings of the Committee on the Healing Arts, 1967.

outpatient clinic than in most hospital practice. Although there is no question about the necessity of medical training as far as hospital psychiatry is concerned, it appears not to be similarly essential to the private practice of psychiatry. In private practice, the same benefits and safeguards to the patient could be achieved *in principle* through the close cooperation of a psychologist, trained to diagnose and treat psychiatric disorders, with a medical doctor. The same question thus arises again: Given the great need for psychotherapists in private practice and in community clinics, why are there so few clinical psychologists trained to give psychotherapy?

The basic reason for the withdrawal of clinical psychologists from the mental health field has been the medical monopoly on training and services in mental health. By and large (and despite real exceptions) physicians, in general, and psychiatrists, in particular, are prepared to cooperate with non-medical mental health professionals, as long as these professionals are subject to the authority and control of the doctors. Thus, statements by physicians about their willingness to cooperate with other mental health professionals must be understood as often being subject to the qualification that the doctor is to exercise ultimate authority and control.

There is a reason for this qualification. A psychiatrist who has been trained in psychodynamics, or a physician psychoanalyst, has a range of medical and psychological expertise that enables him to form a more comprehensive view of the needs of a patient than a non-medical mental health professional can achieve. This capability legitimates the exercise of a special authority that is the prerogative of the psychiatrist. But a psychiatrist who has no psychodynamic training would not be as competent as a non-medical therapist who is an expert in psychodiagnosis and psychotherapy, in evaluating the specifically psychological needs of a patient. Once it is accepted that scientific knowledge and proven diagnostic and therapeutic skill constitute the basis for legitimate authority, the rationale for blanket or monopolistic control of mental health services by medicine vanishes.

The attitudes of psychiatrists in our survey are interesting in this connection. Of a group of 149 psychiatrists, 142 considered medical training to be a prerequisite for performing a psychiatric diagnosis. A smaller number but a substantial majority, ninety, considered medical training to be a prerequisite for psychotherapy. Only thirty-seven considered medical training to be a prerequisite for psychoanalysis (Table 4.10).

There is a special complicating factor that must be grasped in order to understand these attitudes. A medical doctor is now legally responsible for a patient's diagnosis and for the treatment program based on it. Consequently, a medical degree is a legal prerequisite for the performance of a psychiatric

diagnosis. The view of the 142 psychiatrists that medical training is necessary therefore may reflect either or both of two positions: medical training is a scientific prerequisite; a medical degree is a legal prerequisite.

The question then must be asked: Is the legal regulation a valid reflection of scientific and training realities? In one respect it clearly is not. It would be a fair generalization that the psychiatric and psychological training received by medical doctors, with the exception of psychiatrists, places them in a scarcely better position than other university-educated people in identifying mental disorders.¹⁸ Gross disturbances such as the hallucinations associated with psychosis can be recognized by almost anyone; on the other hand, a physician may be as gullible and as easily misled by the more subtle distortions of perception, values, belief and behaviour of the psychoneurosis as a teacher, lawyer or clergyman would be. This fact has been demonstrated by the experience of the general practitioners in the psychiatric seminars established by D. J. McCulloch.¹⁹ The doctors in these seminars found that they had been naively predisposed to believe their patient's representations of their personal situations and had been unable to sift out fact from fantasy. Just this capacity for refined perceptivity is needed in order to make a precise diagnosis of a mental disorder, and it must accompany, of course, its treatment by psychological methods.

Given the amount of psychiatry in the undergraduate medical curriculum, one should not be surprised at this result. Nevertheless, by law any medical practitioner is deemed competent to perform a psychiatric diagnosis. Furthermore, in the existing system the vast majority of psychoneurotic disorders that receive treatment are diagnosed and treated by general practitioners. Our study of OMSIP diagnostic data showed that 91,200 patients had been diagnosed as having a psychiatric disorder during the six-month period of the study. Our survey of physicians (Study 3a) showed that approximately 88 per cent of these patients are treated by the general practitioners themselves. Among the remaining 12 per cent one would expect to find the grosser psychiatric disorders (psychoses and psychopathic conditions) that require hospitalization. These will be seen by a psychiatrist and perhaps also by a clinical psychologist, but they represent only a small fraction of the total patient population.

Clinical psychologists could receive intensive training in diagnosing psychopathology involving both mental handicaps resulting from organic malfunctioning and psychogenetic disturbances. Nevertheless, at present clinical psychologists can diagnose and treat only upon referral from, or in association with, a medical practitioner. These regulations result in a situation in which a professional who may be scientifically — and by training, better-equipped — to perform a service is

¹⁸Substantiation of this point is made in Chapter 5. The major reference is K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963, pp. 306-307.

¹⁹D. J. McCulloch, *op. cit.*

subject by law to supervision from a professional who may be scientifically and by training less well equipped to perform the same service.

There is some division of opinion among psychiatrists as to whether or not the mental health services of clinical psychologists and psychiatric social workers should be rendered only on referral from a physician, but the substantial majority favours this type of control (Tables 4.13, 4.14). A referral is required in order to avoid the risk of a useless and possibly dangerous treatment program being instituted by a non-medical practitioner for a symptom that is caused by a medically treatable organic cause which would perforce go untreated. Some clinical psychologists interviewed pointed out that the danger can be easily exaggerated, but none considered it so negligible as to warrant opposition to the referral requirement. Hence, while the requirement of supervision cannot be sustained, in scientific terms, for psychological services (psychodiagnosis and psychotherapy), the requirement of referral can.

The position that results has three aspects:

- 1) Only psychiatrists who are trained to perform psychodiagnosis and psychotherapy, along with medically trained psychoanalysts, are competent to perform the complete diagnosis of a patient and to undertake appropriate treatment.
- 2) Doctors who are not trained to perform psychodiagnosis and psychotherapy are competent to perform a medical diagnosis and, in cooperation with a properly trained psychologist, to perform a psychiatric diagnosis.
- 3) Psychologists and psychiatric social workers who have been appropriately trained are competent, along with psychiatrists (trained in psychodynamics) and psychoanalysts, to perform a psychological diagnosis and therapy.

The position is taken here (and it will be substantiated in later sections on psychoanalysis and psychology) that there are no scientific or logical grounds or supposing that a medical training is a prerequisite for the acquisition of psychodynamic knowledge and skills. The question remains as to whether or not clinical psychologists in Ontario are adequately prepared to carry out psychodiagnosis and psychotherapy, and whether university departments of psychology are competent to train clinical psychologists to the level of accomplishment that would enable them, in cooperation with a physician, to provide the psychological treatment resources of a good psychiatrist. This question cannot be answered satisfactorily here, but suffice it to say that one factor that has discouraged the development of these skills by psychologists has been the monopoly on mental health services exercised by medicine.

Returning to a consideration of the attitudes of psychiatrists as to whether

medical training is a prerequisite for psychotherapy, we find two important inconsistencies in the responses reported in Table 4.10. Psychoanalysis is by every measure the most powerful form of psychological therapy in existence. It can be the most remedial to the most severe psychoneurotic disorders and, in the hands of an incompetent, it can be the most harmful. Nevertheless, only thirty-seven of 149 respondents were of the opinion that a psychoanalyst must have medical training. Psychotherapy is a less powerful form of treatment. Neither psychoanalysis nor psychotherapy involves, per se, any medications, physical examinations or other medical procedures, except for the initial diagnosis which excludes organic causes and which need not be performed by the therapist. If medical training is not considered a prerequisite for psychoanalysis, why should it be a prerequisite for psychotherapy? It would appear that the attitudes of psychiatrists on this question are governed largely by the official positions taken by the professional bodies concerned. The Canadian Psychoanalytic Society²⁰ does not require that all psychoanalysts have a medical degree; whereas, the Ontario Psychiatric Association has defined psychotherapy to be a medical act.

Can the Ontario Psychiatric Association definition be substantiated? In addition to the theoretical argument offered above, there is one undesirable consequence of this policy. If psychotherapy is a medical act and since general practitioners are trained to perform medical acts, then general practitioners can perform and be appropriately compensated for performing psychotherapy. The Ontario Medical Services Insurance Plan has adopted this reasoning and compensates general practitioners for psychotherapy, although at a somewhat lesser rate than psychiatrists, since they are not specialists. But general practitioners have no training which could equip them to provide this service, unless they have undertaken special postgraduate training; and in fact little of this has been available.²¹ Consequently, the definition of psychotherapy as a medical act has resulted in a "professional" definition rather than a scientific definition; a professional definition which, moreover, in the current systems of education, service and compensation, results in a *gross departure* from the scientific definition.

Consequently, there exists an unjustifiable official attitude of medicine towards psychology which involves a disservice to the public. Psychologists are forced into the humiliating and false position of saying to their clients that they are giving them counselling when they are giving them psychotherapy (and as far as one can tell, with perfect right as far as their training background and experience are concerned). This terminological smokescreen adds to the general public confusion concerning the treatment of mental disorders by psychotherapy. It is, additionally, a disservice to the public to encourage the belief, as this definition and the Ontario Medical Services Insurance Plan do, that a general practitioner is, by training, equipped to treat a mental disorder by means of psychotherapy.

²⁰A description of the role of the Canadian Psychoanalytic Society is contained in Chapter 6.

²¹More detail relevant to this point will be provided in Chapter 5.

An examination of the psychiatric content of the undergraduate medical curriculum of Ontario's five medical schools indicates the following situation: one medical school (University of Ottawa) offers scarcely any training in psychiatry to medical undergraduates; the others do not include systematic training in psychotherapy involving supervised control cases; by and large, psychiatry is greatly overshadowed by the traditional clinical disciplines both qualitatively and quantitatively in the undergraduate medical curriculum. This situation is being slowly improved, but medical undergraduates still report that the place of psychiatry in their undergraduate education tends to diminish their sense of its importance, worth and significance.

There is no scientific or technical justification for establishing a monopolistic control of psychotherapy by medicine. The grounds for rejecting the definition of psychotherapy as a medical act will be presented in a later context in connection with psychoanalysis. Suffice it to say here that what applies in the case of psychoanalysis applies with equal force to psychotherapy.

What changes would remove these inconsistencies in the existing system? Three solutions present themselves. One would be to make psychiatrists legally responsible for performing a psychiatric diagnosis and psychotherapy. This solution has against it four decisive objections. First, medical doctors without training in psychiatry but with training in psychoanalysis would be excluded. Second, there are not enough psychiatrists, nor will there ever be enough, to man the service. Third, some psychiatrists are not trained in the specific diagnostic and therapeutic skills required by psychotherapy. And fourth, there are clinical psychologists who appear to be fully as competent as psychiatrists to perform the service when they can work in cooperation with medical doctors. Another solution would be to greatly improve the training of general practitioners in psychiatry and make no further change in the system. Against this solution there are three objections. First, in the past medicine has not demonstrated much ability to change the undergraduate curriculum in ways that would make physicians really competent to diagnose and treat psychological disorders, and one should not expect too much of it in the future. Second, even if curriculum improvements were made, the service would still need non-medical resources in order to meet social needs. And finally, the system must be adjusted to take into account the competence of appropriately trained non-medical mental health professionals. A third solution would be to modify the system so that any suitably trained person could perform these diagnostic and treatment services — whether he is a physician, psychologist, psychoanalyst or social worker — with the provision that the non-medical professional would be required to carry out a *psychiatric* diagnosis in collaboration with a medical practitioner. The requirement of an initial referral supplemented by periodic check-ups by the referring physician would appear to be a sufficient guarantee of the necessary kind and amount of collaboration.

Conclusions

Ontario needs many more psychiatrists than it now has. The shortage of psychiatrists is one of the most significant causes of the inadequacy of mental health services. A better distribution of psychiatric services to the rural, town and small city population is required. Since this problem is not solved without planning, there is a need for comprehensive community health centres, of a type that would attract good psychiatrists to them, strategically located throughout the province. Steps should be taken to retrieve Canadian physicians practising psychiatry in the United States.

The Departments of Psychiatry in the university medical schools should exercise control over psychiatric training including hospital residency. Everything possible should be done to strengthen training programs in psychiatry in Ontario, especially their psychodynamic content.

The criteria for licensing psychiatrists by the Ontario College of Physicians and Surgeons needs to be modified to make possible the licensing of psychiatrists trained in equally good or better training programs elsewhere.

In order to guarantee appropriate collaboration between physicians and non-medical mental health professionals in the diagnosis and treatment of mental disorders, it is sufficient to require that non-medical therapists treat patients only on referral.

Psychodiagnosis and psychotherapy are two major functions of psychiatrists that can, in principle, be shared with other senior mental health professions, such as clinical psychologists and psychiatric social workers. Rather than defining psychotherapy as a medical act, this study adopts the position that psychotherapy is an interdisciplinary service based on psychodynamic knowledge and therapeutic skills that can be developed by other mental health professionals as well as physicians. The basis for this position will be fully elaborated in the course of subsequent chapters.

Chapter 5 Medicine

Mental Health and the Non-psychiatric Medical Specialties

A survey of non-psychiatric medical specialties was conducted by means of mailed questionnaires (Study 3) and a study of OMSIP data (Study 1). Both studies point to the anticipated conclusion that the medical specialties other than psychiatry are much less involved in the diagnosis and treatment of mental disorders than is general practice, which shares the major burden of responsibility with psychiatry.

Role of Non-psychiatric Medical Specialists in Mental Health

The OMSIP classification of specialties for the period of the study was based on the physicians' self-classification into specialty combinations, resulting in a very fine net through which to sift specialty experience with regard to psychiatric disorders. A number of different specialty groupings emerge when they are classified according to the number of patients seen who are given a psychiatric diagnosis.

First, there are a number of specialties whose practitioners would have no occasion to see psychiatric illnesses because of the nature of their specialty. These are pathology and bacteriology; pathology; bacteriology; diagnosis and therapeutic radiology; diagnostic radiology; therapeutic radiology; endocrinology; proctology, and some other specialty combinations in the same general area of medicine. None of these specialties or combinations of specialties rendered any services to patients with psychiatric diagnoses during the period of the study.

Another group of specialties are those in which the practitioner might see psychiatric problems despite the nature of his practice, but would be unlikely to be involved in the treatment of the disorder (the anaesthetist who gives an anaesthetic to a patient receiving ECT is an exception). The study showed the following specialties and combinations of specialties with less than one per cent of their patients reported as suffering from a psychiatric illness: dermatology; orthopaedics; orthopaedics and general surgery; plastic surgery; general, orthopaedic and plastic surgery; general and plastic surgery; internal medicine and tuberculosis; ophthalmology; otolaryngology; ophthalmology and otolaryngology; urology; urology and general surgery; anaesthesia and paediatrics; and general surgery, obstetrics and gynaecology.

Yet another group of specialties are those whose practitioners are likely to

see some primarily psychiatric disorders and, depending on the circumstances and specific nature of the individual practice, might treat some disorders. The study showed the following specialties and combinations of specialties in which more than one per cent but less than 5 per cent of their patients received a psychiatric diagnosis: anaesthesia; general surgery; neurosurgery; general and neurosurgery; general orthopaedic and thoracic surgery; neurology and internal medicine; obstetrics and gynaecology; obstetrics; paediatrics; and internal medicine and physical medicine. Again, anaestheticians probably appear in this group because of the use of anaesthetic for administering ECT. An inspection of the ratio of services to patients indicates that very little treatment is handled by the specialists in this group once a primary psychiatric diagnosis is established, with the exception of the anaesthetists, for whom the average number of services per patient with a psychiatric diagnosis is well above one service per patient (the ratio towards which the others tend). Obstetrics and gynaecology is the only specialty of the group for which the ratio of services (diagnostic and treatment) closely approaches an average of two services per patient.

A fourth group, which differs from the third only in having a higher frequency of patients with psychiatric disorders, is made up of thoracic surgery (5.5 per cent of patients given a psychiatric diagnosis); internal medicine (5.5 per cent); general surgery and gynaecology (6.2 per cent); gynaecology (7.7 per cent); and physical medicine (8.3 per cent). Here we may assume that patients have come to the specialist with overtly physical symptoms which turn out to be psychogenetic; or they may have been referred by a psychiatric or general practitioner for a consultation to investigate the possibility of an organic determination of an illness already thought to be primarily psychiatric or of uncertain origin. That the former is probably the more frequent occurrence is suggested by the fact that the average service per psychoneurotic patient in this group closely approximates three per patient, indicating treatment for some patients. As one might expect, general surgery and gynaecology were exceptions. For them the treatment-patient ratio approximated one service per patient. Physical medicine was an exception in the opposite direction, with an average rate of seventeen services per patient; this rate exceeds even psychiatry, for which the average is seven.

The final group is one in which the physician would be presented with psychiatric disorders, and would diagnose and treat at least some of those presented to him. These are neurology and psychiatry (with 79.6 per cent of the total patients being psychiatric); neurology (with 14.2 per cent); psychiatry and paediatrics (85 per cent); and psychiatry and internal medicine (88.8 per cent). It is clear from this last group that it is the psychiatric component of a combined specialty that generates a practice in which psychiatric cases predominate. Of the patients seen by psychiatrists in Study 1, 92.1 per cent were given a psychiatric diagnosis, the remaining 7.9 per cent presumably being comprised largely of diagnostic consultations which excluded the possibility of a psychiatric disorder and some non-psychiatric medical services rendered by psychiatrists.

In the population of Study 1, 764,476 persons received some kind of medical service during the period of the study. Of these, 5,310 were reported as having a psychiatric disorder by the specialties enumerated above and were recipients of a consultation with a specialist, or a treatment, or both. If we exclude the specialties combined with psychiatry in group five, this figure is reduced to 4,775 patients. On either classification the conclusion follows that the non-psychiatric specialties in medicine do not, and are not in a position to, contribute significantly to the treatment of mental illness in the population. This conclusion is reinforced by the average number of services per patient with a psychiatric diagnosis by non-psychiatric specialists — this was only two and one-half.

It must be emphasized, however, that these figures represent only general averages and do not represent the realities of individual practice, which in some instances diverge very sharply from the average. The material presented on the comments section of the questionnaires to selected specialties indicates a wide difference of individual practice. There is the physician who will not "see" a psychiatric disorder if it is presented to him, unless it is a patient in an extreme psychotic state. There is the physician who receives patients only on referral, with the result that almost no patients with psychiatric problems are seen by him, unless a psychiatric disorder happens to be an extrinsic concomitant of another illness he has been asked to treat. There is the physician who is on the lookout for the symptoms of mental illness in his patients but seldom, if ever, treats them himself when he finds them, preferring to refer them to a psychiatrist. And there is the specialist who is on the lookout for the symptoms of mental illness in his patients and undertakes the treatment of some of them himself, usually by drugs and/or counselling. The average figures derived from Study 1 are generated by these wide divergences in individual practice. Nevertheless, the general conclusion remains true, that medical specialties other than psychiatry have little to contribute directly to the diagnosis and treatment of mental illness. This situation, after all, reflects a reasonable division of labour among the various specialties.

Training as a Factor in Involvement of Non-psychiatric Specialists

The study based on questionnaires to selected specialties (general surgeons, orthopaedic surgeons, internists, neurologists, obstetricians and gynaecologists) substantiates the general finding of Study 1, but also discloses some additional facets of the involvement of these medical specialists in mental health.

When the data concerning the numbers of psychiatric as compared with all (including psychiatric) cases were analyzed in relation to the decade of training of the physician, a strongly marked difference was found separating specialists who had been trained in the decades prior to the 1930's and those who had been trained later. There were not sufficient numbers in the sample populations for earlier decades than the third, and the seventh decade had to be excluded for the same reason.

TABLE 5.1
Percentage of Patients with an Identified Psychiatric Disorder Seen by
Non-psychiatric Specialists, Associated with Decade of Training

Type of physician	Decade of training	Psychiatric cases seen as a percentage of all cases
Specialists in:		
general surgery,	Third	5.6
orthopaedic surgery,	Fourth	18.2
internal medicine,	Fifth	18.1
neurology,		
obstetrics and		
gynaecology	Sixth	20.4

SOURCE: C. Hanly, *Mental Health Survey: Physicians* (Studies 3b, 3c, 3e, 3f), 1967. Based on a questionnaire survey of Ontario specialists.

Table 5.1 shows a definite watershed during the 1940's, when a substantial increase in the numbers of psychiatric problems recognized by non-psychiatric specialists appears to have occurred and to have been maintained subsequently at approximately the same level. These data suggest that the more recently trained specialists are, for the most part, much more alert to mental health problems in their patients and in a better position to identify, if not to diagnose fully or to treat, such problems.

The moral of the story is, if you want to find a specialist who will be likely to spot a psychiatric problem in yourself or a member of your family, seek out one that established practice or was trained after the Second World War. This greatly increased awareness of mental health problems on the part of medical specialists generally since the Second World War partly explains the formal acceptance of psychiatry as a specialty in medicine, as well as the more important (from society's point of view) informal acceptance and utilization of psychiatry by other specialists, as pointed out in the brief by the Ontario Psychiatric Association to the Committee on the Healing Arts. By and large, psychiatry has won its battle for acceptance within medicine. What now must be dealt with is the greatly increased demand for services of all kinds (treatment, diagnosis, teaching and research) generated by that acceptance.

Evaluation of Psychiatric Resources by Medical Specialists

Compared with the general practitioners in the sample, the specialists found the psychiatric resources in the area of their practice to be substantially more satisfactory, as Table 5.2 shows.

Although a significant number of gynaecologists, obstetricians, internists and general practitioners (almost one-third of each) evaluated psychiatric services as

TABLE 5.2
Evaluation of Psychiatric Resources in Area of Practice by Specialists
Compared with General Practitioners
 (Per cent)

Type of physician	Rating of Psychiatric Services in Practice Area							
	Excel- lent	Good	Ade- quate	Inade- quate	Very Inade- quate	None	No Answer	Not Known
General practitioners	7	22	28	30	11	2	—	—
General surgeons	14	20	26	17	6	9	7	1
Orthopaedic surgeons	21	18	39	14	4	—	—	4
Internists	14	27	21	31	5	1	1	—
Neurologists	13	39	29	13	3	—	—	3
Obstetricians and gynaecologists	17	32	17	30	1	3	—	—

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians.

inadequate, a greater percentage of specialists than general practitioners found psychiatric services in the area of their practice to be excellent, good, or adequate. General surgeons are an exception, since 9 per cent found themselves without any psychiatric services in the area of their practice.

A number of different factors are at work here. First, some specialists see patients only on referral from other physicians who would have screened out almost all psychiatric cases. Those that do get through are referred back when no organic problem is found which the specialist is competent to detect or treat. These specialists obviously would not find handling psychiatric problems a burden. This accounts for the fact that the medical experience of a few specialists is so insulated against mental health problems that they are left in the dark about the extent and nature of local psychiatric services. Second, specialists are more likely to practise in the areas where most of the psychiatrists in private practice are located. This geographical proximity makes referral of patients with psychological problems easier. Third, most specialists have hospital privileges, and when the hospital has a psychiatric unit the specialist is in a better position to acquire these services for his patients. Nevertheless, it is surely not unimportant that of the specialists who responded to the questionnaire, 32 per cent of the general

surgeons, 18 per cent of the orthopaedic surgeons, 37 per cent of the internists, 19 per cent of the neurologists, and 34 per cent of the obstetricians and gynaecologists found local psychiatric services to be inadequate, very inadequate, or non-existent.

Attitudes of Non-psychiatric Specialists to Mental Health

A brief account of the contents of the open comments section of the questionnaire will elucidate further the significance of this dissatisfaction.

General Surgeons

Among the general surgeons a wide range of attitudes towards mental health problems in their patients was expressed. Some indicated that they had no professional interest in these problems at all. (One surgeon commented that most of his fellow surgeons would not recognize a psychiatric problem until the patient jumped out of the window!) Others indicated a strong awareness of the psychological effects of surgery on their patients. Yet others indicated an active interest in the total health problems of the community and, specifically, mental health problems in their patients.

The most frequent comment dealt with the need for more psychiatrists, especially in private or community clinic practice. Some surgeons also recognized the need for psychologists and social workers. Difficulty in securing psychiatric services for the treatment of severe psychoneurotic problems without hospitalization is a major problem. There may be delays in receiving consultations and in having patients taken into treatment; there may be a lack of intensive long-term treatment (treatments were thought to be too "episodic" to accomplish much); and there may be too much reliance on drugs, either because psychiatrists are pressed for time or because they are not trained in psychotherapy.

It was remarked that two special services are lacking: treatment services for emotionally disturbed and physically handicapped children, and services for psychiatric emergencies. These comments usually were combined with recommendations for more personnel rather than more facilities, and for better coordination of available resources. Apparently many surgeons rely on general practitioners to carry a major responsibility for diagnosing and treating mental health problems. Several said they were reluctant to confront their patients with the fact of a psychoneurotic problem because of negative patient reactions. Some surgeons deal with minor psychopathological reactions to surgery and a few, particularly those whose surgical work is part of a general or family practice, treat the symptoms of some psychoneurotic disorders by means of counselling and/or drugs. But, for the most part, the burden not taken up by psychiatry is left to general practice.

Orthopaedic Surgeons

The general tenor and range of comments by orthopaedic surgeons was very

similar. However, to correct any impression that all specialists in metropolitan areas find psychiatric services satisfactory, a quote in length from one questionnaire is included:

I feel that the psychiatric services in this city (Toronto) are totally inadequate from the point of view of an orthopaedic surgeon. In the large general hospital the psychiatrists are usually much too busy to adequately examine the patient and give you a proper opinion as to the patient's condition and his management. Many patients whom you carefully examine are often assessed psychiatrically from the foot of the bed and treatment suggestions are also often made in the same way.

I have also found a great reluctance on the part of psychiatrists to accept cases at all. This is especially true of places like the Clarke Institute and other psychiatrists in practice in the downtown area. My own feeling is that the problem is quite acute and an entire reorganization of psychiatric services in Ontario is needed.

Internists

It is apparent, from their comments, that internists see many more patients with significant psychological problems and that (as one would expect) they treat more of these patients themselves than do surgeons. In particular, internists frequently are presented with the tasks of treating alcoholism; hence, if the physician is dealing with the complete patient rather than just with his liver or blood, he must look at the psychological and social conditions involved. But unless the practice is highly specialized and on an exclusively referral basis, the internist also sees the full range of psychoneurotic and psychotic disorders. Internists, like surgeons, repeatedly emphasized the need for more psychiatrists in private practice, more clinics dispensing individual and group psychotherapy to which they could refer patients, better emergency services, and more and better opportunities for consultations with psychiatrists. Internists were particularly concerned about the need for improvement in the amount and quality of follow-up care for patients who have been discharged from hospital, and for better liaison between themselves and the hospital with respect to both reports on the progress of patients in hospital and discharge reports. A number of internists recommended the further involvement of psychologists and social workers in mental health as psychotherapists, supporting this recommendation by advocating that such diagnostic and psychotherapeutic services rendered by these professionals should be covered by OMSIP or its equivalent.

Neurologists

Again, comments by neurologists followed a similar pattern. Some neurologists, however, criticized the psychiatrists for not being as knowledgeable as they might be about brain physiology. One neurologist criticized the continued, frequent use of ECT by psychiatrists, despite evidence of damage to the brain caused by the treatment. This criticism raises a major issue, which we will outline here and discuss in detail later. The Ontario Psychiatric Association brief states that psychiatrists can and do perform a physical examination of patients presenting

psychological or psychogenetic symptoms in order to eliminate organic causes because they are physicians, whereas clinical psychologists and other mental health professionals have neither the technical expertise nor the legal authority to do so. But some of the comments by neurologists suggest that, while psychiatrists legally are competent to perform a physical examination leading to a differential diagnosis, they do not always have the technical expertise, either because of training deficiencies or because their knowledge of brain physiology and brain diseases has not been kept up to date. From the point of view of some neurologists there is a need for more teamwork, closer cooperation between neurology and psychiatry. The recent (January 1965) case of Terrance Greenlaw underlies the problem. The twelve-year old boy died of an undiagnosed brain tumor two weeks after being released from Peterborough Civic Hospital to undergo psychiatric treatment for headaches and vomiting. In an interview, Dr. H. Kravitz, Psychiatrist-in-Chief of the Jewish General Hospital in Montreal, stressed the fact that tumors in a specific region of the brain can cause a psychological depression that can easily be diagnosed as psychogenetic.

Thus, it may be that the conditions under which the psychodynamically oriented psychiatrist works in performing psychological therapies are not, in practice, intrinsically different from those of the psychodynamically oriented psychologist. Through liaison with allied experts such as neurologists, similar safeguards should be adopted by psychiatrists. Such, in fact, is the procedure of many psychiatrists.

The problem that no procedure can solve *automatically* is the identification of unusual cases; for unusual cases often do not *appear* to be unusual and a neurological investigation would not *necessarily* disclose the problem. Nevertheless, the need exists for a more thorough examination of the problem of professional training, practice and jurisdiction.

Gynaecologists and Obstetricians

Comments by gynaecologists and obstetricians also followed the pattern established by the other specialties; those with highly specialized referral practices tend to see few and to treat no psychiatric problems. Others report that up to 30 per cent of their patients have psychoneurotic difficulties. Practice differs widely with respect to the extent to which any attempt is made to treat psychoneurotic patients. These specialists emphasized the need for marriage counselling services, and the need to involve more psychologists and social workers in providing such services through community mental health centres.

In summary, all specialists commented on the need for more psychiatrists, especially in private practice, and for more community mental health centres offering a diversity of services. The dominant fact that emerged concerning current treatment of mental health problems in Ontario was that general practitioners carry a heavy burden in identifying all kinds of mental illness, performing

at least preliminary diagnosis and (insofar as the illness is identified and treated at all) treating the bulk of psychoneurotic disorders in the population.

Mental Health and General Practice

Awareness of Mental Health Problems

The increase in awareness of mental illness among their patients by general practitioners has followed a pattern similar to that of specialists. Again, we find that the Second World War marks a watershed between relatively lower and higher levels of awareness, as Table 5.3 shows.

TABLE 5.3
Percentage of Patients with an Identified Psychiatric Disorder Seen by
General Practitioners, Associated with Decade of Training

Type of physician	Decade of training	Cases given a psychiatric diagnosis as a percentage of all cases
General practitioners	Third	7.8
	Fourth	8.7
	Fifth	16.9
	Sixth	19.9
	Seventh	21.8

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3a)*, 1967. Based on a questionnaire survey of Ontario general practitioners.

The sudden increase between the fourth and fifth decades appears to be less the result of changes in the training of general practitioners than the result of changes in the general culture to which every educated person, including the general practitioner, is subject. This suggestion is based on the findings of Clute. Fifty per cent of the Ontario general practitioners in his study considered that their undergraduate education in psychiatry had been unsatisfactory, and that, in general, doctors who took some interest in mental health problems in their patients were guided in their interventions more by personal life experience than by their medical training.¹ Interviews with a group of medical undergraduates at the University of Toronto indicated that the situation has not yet been corrected; from the recipient's point of view, undergraduate education in psychiatry is still distinctly inferior to that in other branches of medicine. This situation was thought to be highly undesirable by the students interviewed. A survey of the calendars of Ontario's five medical schools indicates that the quality and quantity of psychiatric content in the undergraduate medical curriculum is as good at the University of Toronto as anywhere, with the possible exception of McMaster which has not yet been put thoroughly to the test. The University of Ottawa does not teach enough psychiatry to undergraduates in medicine to warrant inclusion of courses in the calendar.

¹K. F. Clute, *op. cit.*, pp. 348-350, 352-353.

TABLE 5.4

Comparison of the Numbers of Patients and Services Received According to Psychiatric Diagnosis, Seen by General Practitioners, Psychiatrists and other Medical Specialists

Type of physician	Numbers of psychiatric patients and services (in thousands)					
	Psychosis		Psychoneurosis		Character and behaviour disorders	
	Patients	Services	Patients	Services	Patients	Services
General practitioners	2.4	5.9	33.6	79.4	1.6	3.7
General surgeons	.04	.07	.9	1.5	.02	.04
Internists	.6	1.0	1.6	3.2	.03	.06
Neurologists	.01	.02	.2	.3	.007	.009
Obstetricians and gynaecologists	.02	.07	.4	.8	.01	.02
Psychiatrists	.7	3.3	4.3	26.8	.4	1.2

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967. Based on a computer tabulation of diagnostic and service data contained on OMSIP claim cards for the period May 1-October 31, 1967.

Extent of Treatment of Mental Disorders

Despite this training handicap, it is evident that general practitioners are seeing and attempting to treat an increasing variety of mental illnesses. Once the necessary allowances are made for the inherent limitations of the OMSIP data, this extensive involvement of general practitioners in mental health can be clearly delineated relative to other types of medical practitioners (see Table 5.4). Our analysis is based on the assumption that the factors making for conservatism in reporting psychiatric disorders would apply equally, on the average, to all physicians except psychiatrists.

These data do not include all patients diagnosed as having a psychiatric diagnosis and treated for the diagnosed disorder by the physicians enumerated in Table 5.4. Multiservice psychiatric claims are not included, but will be dealt with later. It cannot be ascertained how many of the services in the table were diagnostic alone and how many were diagnostic plus treatment. Nevertheless, where the number of services closely approximates the number of patients, it is obvious that, for the most part, the services rendered are diagnostic only. The data clearly suggest that the non-psychiatric specialties, as compared with general practice, contribute little by way of treatment for mental health problems when measured by either of two criteria: the number of patients involved, or the total number of services rendered to patients with a psychiatric diagnosis. During the six-month period of the study the four non-psychiatric specialties gave approxi-

Alcoholism		Other		Organic causes		Total	
Patients	Services	Patients	Services	Patients	Services	Patients	Services
.02	.05	1.3	2.2	.06	.09	38.9	91.2
—	—	.03	.04	.002	.004	1.0	1.6
.001	.001	.04	.07	.001	.001	2.3	4.3
.001	.004	.04	.09	.001	.001	.3	.4
—	—	.03	.08	.001	.001	.5	.9
.009	.010	.1	.3	.01	.02	5.5	31.6

mately 7,200 services to approximately 4,100 patients; psychiatrists gave 31,600 services to 5,500 patients; and general practitioners gave 91,200 services to 38,900 patients. Clearly general practice is carrying the major burden of medicine's contribution to mental health in the province.

Particularly striking are the data concerning the most severe and debilitating mental illnesses: psychoses, and character and behaviour disorders. General practitioners saw 2,400 psychotic illnesses, and 1,600 character and behaviour disorders during the period of the study, dispensing to each group of patients 5,900 and 3,700 services respectively. The non-psychiatric specialties together saw 670 psychoses, and 437 character and behaviour disorders, and rendered 1,160 and 669 services respectively; and psychiatrists saw approximately 700 psychoses, and 400 character and behaviour disorders, rendering 3,300 and 1,200 services to each patient group. Thus, general practitioners are carrying also a major share of the services to non-hospitalized persons suffering from psychoses and character and behaviour disorders.

This tendency is certain to be continued and accelerated because of changes that have come about in the treatment of psychosis in hospital. The development of psychotropic drugs for the treatment of psychotic illnesses has resulted in a substantial decrease in the length of stay in hospital for treatable cases. This achievement is being largely negated, however, by a corresponding increase in the number of re-admissions. If real strides are to be made in the long-term treatment

of psychoses, more adequate post-hospital therapeutic management will have to be developed. And as these services are developing currently, a large share of the problem will certainly fall to general practitioners.

Data on multiservice OMSIP claims provide information concerning yet another aspect of psychiatry in general practice as compared with other medical specialties. Multiservice psychiatric claims on the OMSIP file have the disadvantage of providing no information concerning diagnosis, but the compensating advantage of providing information about more intensive long-term treatment. Multiservice claims are those that contain a number of services over a period of time rendered to a single individual and submitted on a monthly basis by the patient or physician to OMSIP. These data, then, provide information concerning the extent to which general practitioners, as compared with specialists, are involved in intensive treatment programs for mental illness among their patients (see Table 5.5).

TABLE 5.5

Comparison of General Practitioners with Psychiatrists and other Specialists with Respect to Provision of Intensive Long-term Treatment of Mental Disorders

Type of physician	Psychiatric Patients	multiservice Services	Average number of services per patient
General practitioners	3.2	74.9	23.2
General surgeons	.07	.9	7.8
Internists	.2	1.8	10.3
Neurologists	.04	.5	12.9
Obstetricians and gynaecologists	.02	.2	10.5
Psychiatrists	1.0	16.2	16.2

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967. Based on a computer tabulation of diagnostic and service data contained on OMSIP claim cards for the period May 1-October 31, 1967.

It emerges that general practitioners in the province treated more than three times as many psychiatric illnesses in private practice on an intensive basis as psychiatrists (approximately 3,200 as compared with 1,000). Each patient was seen twenty-three times on average when in intensive treatment by a general practitioner and sixteen times when in intensive treatment by a psychiatrist during the six-month period of the study. The contributions of other specialists were small in comparison with either general practice or psychiatry. Even when one

discounts the patients of the two or three psychoanalysts (who, because of the anomalies in the province's licensing procedures, are classified by OMSIP as general practitioners) whose patients account for an infinitesimal fraction of the total, it is clear that general practice already occupies a crucial role in providing diagnostic and treatment services in mental health with or without the necessary training.

Finally, the same conclusion is reinforced by the treatment and referral data concerning psychiatric problems in our Mental Health Survey: Physicians (see Table 5.6).

TABLE 5.6

Comparison of the Treatment of Psychiatric Disorders by General Practitioners and Certain Medical Specialties

Type of physician	Percentage of psychiatric problems treated by physician himself	Percentage of psychiatric problems referred to others	Percentage not needing or refusing treatment
General practitioners	88.1	8.7	3.2
General surgeons	71.6	23.0	5.4
Internists	76.2	19.8	4.0
Neurologists			
Obstetricians and gynaecologists	52.4	27.8	19.8
	82.7	11.1	6.2

SOURCE: C. Hanly, Mental Health Survey: Physicians (Study 3), 1967. Based on a questionnaire survey of Ontario physicians.

General practitioners see more psychiatric problems, treat more of these patients, and refer fewer of them than any other type of physician, with the sole exception of psychiatrists.

Treatment Methods

Accurate information concerning the nature, quality and efficacy of treatment is difficult to obtain. The data concerning treatment methods on the questionnaires often appeared impressionistic. Nevertheless, a rather consistent treatment pattern emerged in which approximately one-half of the patients were treated with a combination of drugs and counselling, one-quarter received drugs only, and one-quarter received counselling only. The major exceptions were neurologists, and

obstetricians and gynaecologists, who appear to utilize counselling by itself more often than the other physician groups in the sample. Table 5.7 summarizes the results.

TABLE 5.7

Treatment Methods Used for Psychiatric Disorders by General Practitioners and Specialists

Type of physician	Relative utilization of counselling, drugs and a combination of counselling and drugs by the physician in the treatment of psychiatric disorder in his own patients (% of patients)		
	Counselling	Drugs	Drugs and Counselling
General practitioners	22	29	49
General surgeons	24	28	48
Internists	21	21	58
Neurologists	34	15	51
Obstetricians and gynaecologists	44	14	42

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians.

Drugs are involved in the treatment of over 75 per cent of these patients, and they are used as the unique means of treatment for 50 per cent of them. It was not within the competence of this study to evaluate the efficacy of this use of drugs for treating mental illness. Psychodynamically oriented psychiatrists take the view that the use of drugs serves as a palliative for certain of the symptoms of psychoneurotic disorders but does not influence their causes. Drugs may provide some relief from the distress of the symptoms and facilitate the management of the disorder but will not by themselves bring about a restoration to health. If this is true, the contribution of the general practitioner to mental health is rather narrowly circumscribed, insofar as he is heavily dependent on the use of drugs for treatment purposes.

The efficacy of counselling depends on three basic factors in the therapist: time, attitude and training. Obviously it is very difficult for general practitioners to satisfy the first condition. The majority are too busy to spend the necessary amount of time with disturbed patients. It would appear from Clute's work that most general practitioners cannot be expected to be challenged by the prospect of treating a patient who has a psychiatric problem. Clute's finding, based on a sample of Ontario and Nova Scotia general practitioners, shows a remarkable consistency of attitude running precisely counter to what one would like to find. For example, of forty-four physicians visited, thirty-six found obstetrical cases positively enjoyable, seven had no strong reaction, and one found them distasteful. Their responses to non-traumatic surgical cases were basically similar. But only two

physicians found the clinical problems presented by alcoholism enjoyable, whereas thirty-one found them distasteful. Four found behaviour problems in children enjoyable and seventeen found them distasteful. Twelve found emotional problems enjoyable and thirteen found them distasteful.² It is not surprising that only 7 per cent of the physicians in Clute's sample evinced a special professional interest in the emotional problems of their patients.³ Clute's comments on the merit of the general practitioner's training and its contribution to his handling of mental health problems in his patients is so pertinent that it must be quoted at length.

It was apparent from discussion with the practitioners that they believed that patients with serious mental illnesses should be referred to psychiatrists as soon as possible but whether these illnesses were generally recognized, we are unable to say. After observing the handling of many patients, we were left with the impression that the general practitioners, in dealing with their patients' emotional problems, were basing their practice on their personal experience rather than on any professional preparation that they had had for such practice. Extremely rare was the physician who attempted to gain a clear picture of the particular situation and to explore the underlying causes in more than the most superficial way. Therapy comprised sedative drugs and brief, directive advice. It appeared that, apart from advice about physical matters, a clergyman or a lawyer, if he had been as well disposed as was the doctor and if he had had as many years of experience with human problems, would have been able to counsel as effectively as most of the practitioners; and some psychiatric social workers are probably a good deal more effective at this. In brief, the general practitioner's handling of emotional or psychological problems appeared to be based on personal, rather than professional qualifications. The vast majority of the practitioners gave the impression that they attempted to deal with these problems, not because of interest in them, but because the problems were wished upon them and were inescapable.⁴

It follows that one should not exaggerate the capacity of general practice as it now functions to carry successfully the mental health burden that has been forced upon it. Although the following facts do not provide any basis for criticizing Clute's evaluations (nor are they intended as such), they do provide the basis for a somewhat more optimistic outlook.

Supplementary Psychiatric Education

The general practitioners surveyed for this report (Study 3a) were invited to report any supplementary postgraduate education psychiatry they had received or were receiving. The results are tabulated in Table 5.8 according to the decade in which medical training was received.

A percentage figure very close to Clute's 7 per cent occurs for the group of physicians in the sample who were trained during the second, third and fourth

²*Ibid.*, p. 232.

³*Ibid.*, p. 234.

⁴*Ibid.*, pp. 306-307.

TABLE 5.8
Postgraduate Education in Psychiatry Among General Practitioners

Decade of training	Some additional psychiatric training		No additional psychiatric training		Total	
	No.	%	No.	%	No.	%
Second, third						
fourth	4	10	36	90	40	100
Fifth	11	20	45	80	56	100
Sixth	24	19	101	81	125	100
Seventh	5	10	47	90	52	100
Total	44	16	229	84	273	100

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey on Ontario general practitioners.

decades, and for those trained in the seventh. However, those trained in the fifth and sixth decades show a substantial difference: in each case about 20 per cent of the physicians had taken some additional postgraduate training to help them improve their clinical work with mental health problems. The variance from Clute's percentage is really twofold: the measure of interest for our percentage is perhaps somewhat more stringent than Clute's, because it requires a physician to have actually taken an additional course of some kind (internship as part of the training for general practice being excluded). Even so, the percentage figure for the two lowest groups was 10 per cent and for the highest (fifth and sixth decades) it was 20 per cent. The first discrepancy could perhaps be accounted for by the fact that physicians who were particularly interested in the mental health problems of their patients would be more likely to respond to a mailed questionnaire and that Clute's estimate, although more disappointing, is more realistic. It would be difficult to explain the second discrepancy (20 per cent) in this way. When the population is stratified according to the decade of training, a substantially larger group of doctors in the prime years of their practice appear to take an active interest in mental problems than Clute's study would suggest.

The conclusion provides scant grounds for optimism, however, and does not support the proposition that general practice is now in a position to discharge effectively the mental health treatment responsibilities thrust upon it by the failure of other professions to keep pace with need. It must be pointed out that, although the criteria of interest used above were quite stringent, the criteria of what counted as additional postgraduate training were not. They included: regular attendance at conferences on mental health, one to two-week special courses on mental illness, partial psychiatric residency, having been psychoanalyzed, attendance at special evening tutorial instruction for general practitioners by psychiatrists,⁵ and a period of employment after graduation in a psychiatric clinic or

⁵See D. J. McCulloch, *op. cit.*

similar facility. Obviously the training value of these diverse experiences will vary considerably. Only one physician mentioned having undertaken a personal analysis. A number mentioned attendance at seminars given by psychiatrists and organized in Ontario by D. J. McCulloch. These experiences are well calculated to correct the major flaw in the psychiatric aspects of general practice noted by Clute. Attendance at conferences and courses of one or two weeks' duration would be less likely to do so.

It must be pointed out that when general practice is considered in relation to the prevailing demand, let alone the prevailing need, the proportion of general practitioners who combine interest with requisite training is woefully inadequate. Furthermore, even with the additional training needed to perform effective psychotherapy, it is not clear that the vast majority of general practitioners will ever have the time available to treat the more serious cases. Thus, the time factor will set limits on the contributions that future generations of general practitioners can make to mental health, even with a better orientation and training than most general practitioners now appear to have.

Remedial Educational Measures

Medical educators are aware of the problem and a number of steps have been taken to remedy inadequacies in the training of physicians now in practice, as well as to improve and expand the psychiatric, psychodynamic and behavioural science content of the undergraduate curriculum. In order to provide some remedy for the first problem the College of General Practice has undertaken to support any program designed to improve the doctor's therapeutic skill in dealing with emotional illnesses. In 1965 the Ontario Chapter of the College of General Practice, in cooperation with the Ontario Psychiatric Association and the University of Toronto, undertook a series of weekly seminars conducted by a psychiatrist with approximately six general practitioners in each. These seminars received over 200 applicants in 1965, although for geographical reasons only 140 could attend. The program has been continued because of its success. Some of its benefits are reflected in the data of the questionnaires in the Mental Health Survey: Physicians conducted for this report. Unfortunately, this program has failed to expand during 1967-1968 and appears to be faltering, not because of any lack of interest among general practitioners nor because of lack of psychiatric tutors, but partly because the government has failed to provide the necessary financial and organizational support that is needed to place it on a stable permanent footing. In addition Dr. McCulloch who, as Chairman of the Ontario Psychiatric Association's Committee on General Practice Education, provided the leadership and drive that initiated the program and saw it through its first two years, has retired in order to take up a new post at the University of Toronto. It is essential that this and other programs of a similar nature be continued and

expanded. As Dr. McCulloch put it, one-day, two-day, or two-week refresher courses in psychiatry for physicians are not much good because there is little or nothing there to refresh.⁶

The new medical school at McMaster University is seeking to correct the situation for the future by providing greater psychiatric content in the undergraduate medical curriculum. Traditionally the medical curriculum has been dominated by four major clinical subjects: surgery, internal medicine, obstetrics and gynaecology, and paediatrics. A quotation from the *British Medical Journal* substantiates this point: "As late as 1960 an international survey submitted to the World Health Organization could state that 'in the United Kingdom and British Commonwealth psychiatric teaching in general is still hardly a legitimate part of the medical curriculum, in spite of repeated requests for improvement, which have come from both faculty and undergraduates.'"⁷ This finding is confirmed by interviews with medical students who had had an interest in psychiatry and abandoned it after taking the undergraduate course in psychiatry offered at their university medical school; it is supported also by psychiatrists who received their medical education in Ontario and retained their interest in psychiatry despite their undergraduate educational experience, rather than because of it. In 1967 Britain's General Medical Council gave psychiatry the status of a major clinical subject; but it does not, of course, follow automatically from this that it enjoys such a position in the curriculum of the British medical schools at the present time. It is reported that the new Nottingham Medical School — described as being "unfettered by established traditions and vested interests" — is most likely to implement the policy of the General Medical Council effectively and at the earliest date.⁸

In many respects the new McMaster medical school is in a similar position. Under the leadership of N. B. Epstein, who is chairman of the Department of Psychiatry, a psychoanalyst and an expert in family therapy, it is hoped that psychiatry will achieve its needed place in the education of physicians, especially those who plan a career in family practice.

It is easy to exaggerate the extent to which the kinds of improvement that are now afoot in the teaching of psychiatry in the faculties of medicine will solve the manpower problem in mental health. McMaster has the advantage of a fresh start that psychiatric educators in other centres do not have. It is unlikely that educators in the established schools will be able to overcome the inertia inherent in long-standing programs and attitudes any more quickly than other university faculties and departments. Even if the curriculum is rapidly improved, it is not yet clear whether or not it will arrest the trend away from general practice among

⁶These observations are based on published works cited above and field interviews with Dr. McCulloch.

⁷"Teaching the Behavioural Sciences", *British Medical Journal*, No. 5572, 1967, p. 123.

⁸*Ibid.*

medical students. If, however, the introduction of a more thorough education in psychological medicine does have this effect, it will have two highly desirable results: 1) it will attract into family practice young persons who otherwise would have been altogether lost to this much needed area of medical service; 2) it will attract into family practice those young persons who are positively oriented towards mental health problems in their future patients, and thus will produce general practitioners who do not have the defects of attitude discovered by Clute. But against these advantages must be balanced the fact that it is not clear how deeply involved most general practitioners can become in the treatment, as distinct from the identification, of psychiatric disorders without detracting from their other necessary medical functions. This will depend in part on how many family practitioners can be recruited and trained; but it also depends in part on the level of training that can be achieved. It is, therefore, important to define more precisely the role of the general practitioner in mental health.

Role of the General Practitioner in Mental Health

At the present time specialists typically expect that general practitioners will handle the mental health problems of physically ill persons. When a patient is referred to a specialist for a consultation which discloses no pathology treatable by the technology available to the specialist, the patient will be returned to the general practitioner for referral or treatment. This process obviously assigns to the general practitioner a crucial role in the identification of mental illnesses and disorders, and in the guidance of such patients to proper treatment dispensed either by himself or by a specialist in private practice, hospital or clinic, depending on the nature of the problem. Although other professionals may be equally well placed, no one can be in a better position to perform this service than a family practitioner with a solid training in psychological medicine and an established practice in a community. This role is clearly essential, and needs to be improved by better education and by the development of adequate services to which referrals can be made by general practitioners.

What is less clear is the nature and extent of *treatment* by general practitioners. Certain specific treatment functions appear to be generally accepted as falling within the province of general practice. These are the rehabilitation of hospitalized patients, the management of patients during their post-hospitalization period with a view to preventing relapse, the treatment of long-term psychosomatic disabilities and addictions, the use of psychodynamically oriented counselling for the treatment of minor psychoneurotic and behaviour disorders, the utilization of community resources for social amelioration, and the handling of psychiatric emergencies. These are enumerated or implied in the description of the psychiatric role of the family physician by the College of Family Physicians of Canada.⁹ They are contained also in the discussion of the role of the general

⁹*Training in Family Medicine*, prepared by the Committee on Advanced Training, the College of Family Physicians of Canada, 1967.

practitioner in the Eleventh Report of the Expert Committee on Mental Health of the World Health Organization.¹⁰

The General Practitioner's Limitations

The same sources clearly place the use of formal psychotherapy (that is, a program of intensive psychological treatment) outside the competence of either the adequately prepared general practitioner or the specialist in family practice. Although some of the psychiatrists interviewed for this study took the view that psychotherapy is an instrument that the general practitioner can use appropriately (this view was supported by a majority of the respondents to our questionnaire survey of psychiatrists), it appears that psychotherapeutic treatment is best left to others, except in the case where the general practitioner has received specialized postgraduate training in psychotherapy. Given the need for the whole range of therapeutic and diagnostic skills of the general practitioner, it would be uneconomic to have him heavily involved in this time-consuming work, quite apart from any considerations about the adequacy of his training. At present the treatments most frequently used by general practitioners are pharmacological (sedative or stimulant drugs with some use of psychotropic drugs). Psychological treatment appears to consist, with some exceptions, of the establishment of a supportive relationship with the patient, to which there is sometimes added some interpretation and advice. The interpretation usually takes the form of presenting to the patient the relationship between the patient's life habits, relationships, and socio-economic conditions and his symptoms. The physician tries to enhance the patient's understanding of the genesis of his distress and provide him with enough self-understanding to make the physician's advice as to what changes might produce an improvement at least somewhat useful and effective. What is usually absent in even the best counselling, however, is the time, knowledge and skill necessary for making psychodynamically significant interpretations that will stimulate the kind of psychic change which is the specific benefit of psychotherapy. Without this additional factor any serious psychoneurotic or behaviour disorder will prove to be highly intractable, despite the best intentions and efforts of the physician and the patient. Thus, usually only those emotional problems that have a major situational component, which the patient — reinforced by the physician's support and an improved understanding — is able to alter himself, will be remedied by the psychological techniques that the general practitioner has at his disposal.

The frustration and dissatisfaction that many general practitioners experience in this area of their practice is not simply the result of inadequate training in psychiatry; it is also the result of the nature of the forces in the lives of persons with which they have to contend. The more severe psychoneurotic and personality

¹⁰*The Role of the Public Health Officers and General Practitioners in Mental Health Care*, World Health Organization Technical Report Series, No. 235, New York, 1962, pp. 15-32.

problems require more intensive and expert treatment than general or family physicians can provide, if they are to continue to provide the other necessary medical services needed by the community. Thus, there are intrinsic limits to the contributions that general practice can make to mental health. It is unlikely that general practitioners will ever become a substitute for psychiatrists, or reduce the current and future needs for psychiatric and psychological specialists. To be sure, with better integrated services and better prepared general practitioners, hospital admissions and re-admissions may be reduced by improved preventive and rehabilitative measures. But this gain is likely to be offset by increases in the demand for specialist treatment of neurotic and behaviour problems as physicians and their patients become more aware of psychological problems and the possibilities for their treatment.

Finally, we must remember that these last paragraphs describe what may come about in general practice in the next decades; the picture of what is actually available to the public at the present time (as drawn by Clute) is not so promising. One must not forget Clute's judgement with regard to psychological therapy that "... some psychiatric social workers are probably a good deal more effective" than general practitioners. This reminds us of the other mental health professions and the distinctive contributions they have to make. We are presented, as well, with a basic question. If a large number of psychiatric disorders can be treated successfully and without any additional hazard to the well-being and health of the patient by non-medical therapists, should not the province's universities be training many more clinical psychologists and psychiatric social workers for work in hospitals, community clinics and private practice than they now are? The importance of this question would be greatly enhanced if it could be established that four objectives could be achieved in this way: 1) a more equitable distribution of mental health services to the population; 2) the recruitment of more personnel who would not otherwise be recruited to the field via medicine; 3) the recruitment of more personnel without adversely affecting already scarce necessary services; 4) the provision of sufficient numbers of mental health professionals so that at least existing services could be adequately manned by trained personnel.

An Injustice in the Current System

There is, in fact, an injustice inherent in the existing system in which medicine dominates the provision of mental health services on a private practice basis. This fact emerged from the OMSIP Diagnostic Data Analysis (Study 1). The relevant data are presented in Table 5.9. The inequality can be measured in two ways: 1) by the percentage of patients receiving treatment from the different socio-economic groups represented by socially assisted, low income and full paying OMSIP subscribers; 2) by the average number of treatments received by individuals from these socio-economic groups. The first will measure the relative success of lower and higher income groups in competing for specialist services in mental

TABLE 5.9
Comparison of Psychiatric Treatment Patterns Associated with Three
Socio-economic Groupings of OHSIP Subscribers
 (Single Service Claims)

Type of physician	Socio-economic grouping of patients with a psychiatric disorder					
	Socially assisted patients		Low income patients		Full paying patients	
	Average no. of services	%	Average no. of services	%	Average no. of services	%
General practitioners	3	34	4	42	4.5	24
Psychiatrists	5.5	19	6.5	31	8	50
Composition of study population		28		46		26

SOURCE: C. Hanly, OMSIP Diagnostic Data (Study 1), 1967. Based on a computer tabulation of diagnostic and service data contained in OMSIP claim cards in the period May 1-October 31, 1967.

health. The second will measure the amount of service an individual from one of these groups can command relative to individuals from other groups.

It is clear from the OMSIP data that the biblical law — “to him that hath it shall be given” — applies to the distribution of specialized psychiatric services in mental health. The last horizontal column gives the actual socio-economic composition of the study population. It defines a population in which 28 per cent are welfare, 46 per cent are assisted, and 26 per cent are full paying. Assuming a uniform distribution of psychiatric disorders, the percentages of psychiatric cases treated by general practitioners and psychiatrists would closely approximate the percentages for the socio-economic composition of the study population, if the services in question were equitably distributed. They are not so distributed. The two percentage figures are approximate for general practitioners. But they are highly divergent for psychiatry. The study population has only 26 per cent full paying members, by 50 per cent of the psychiatrists’ services are rendered to full paying OMSIP subscribers. The study population has 28 per cent socially assisted members but only 19 per cent of the psychiatrists’ services are rendered to socially assisted OMSIP subscribers. Similarly, 46 per cent of the study population are low income patients, but only 31 per cent of the patients of psychiatrists are low income OMSIP subscribers.

Turning to the amount of service given to individuals in these socio-economic groups, we find a similar bias. More general practice care is given to patients as one moves up the socio-economic ladder. Socially assisted patients receive on the average three services, low income receive four, and full paying receive four and

TABLE 5.10

Comparison of Psychiatric Treatment Patterns Associated with Three Socio-economic Groupings of OMSIP Subscribers (Multiservice Claims)

Type of physician	Socio-economic grouping of patients with a psychiatric disorder					
	Socially assisted patients		Low income patients		Full paying patients	
	Average no. of services	%	Average no. of services	%	Average no. of services	%
General practitioners	15.5	30	23.5	44	26.5	26
Psychiatrists	12	19	15	31	18	50
Composition of study population		28		46		26

SOURCE: C. Hanly, OMSIP Diagnostic Data Analysis (Study 1), 1967. Based on a computer tabulation of diagnostic and service data contained on OMSIP claim cards for the period May 1-October 31, 1967.

one-half from general practitioners. This bias is much stronger in psychiatry — socially assisted patients receiving, on the average, five and one-half services per patient, low income receiving six and one-half, and full paying receiving eight services. Consequently, the full paying patients also receive the best treatment and command considerably more than 50 per cent of treatment services from psychiatrists.

Essentially the same pattern is reflected in the analysis of multiservice psychiatric claims. As already pointed out, the multiservice psychiatric claim refers to a relatively intensive program of treatment in which several services per month are involved resulting in monthly billing of the patient.

OMSIP, which provides for the best coverage of psychiatric services of any insurance scheme in existence, will rectify this situation *in principle*. But it will do so, in fact, only if four conditions prevail which do not now exist: 1) if there are enough psychiatrists to provide specialist services to all who need them; 2) if psychiatrists choose to treat patients irrespective of their socio-economic background and education; 3) if the public is able and prepared to support the costs involved in the expansion of the supply of psychiatrists; 4) if the poor become as well educated as the well-to-do about health resources and their use. It is the difficulties involved in all four of these conditions that makes it so important to consider seriously what other alternatives we have for training specialists in psychological medicine who could offer widely needed non-medical mental health services.

Conclusion

The detailed examination of the training and contributions of physicians other than psychiatrists has confirmed the conclusions of Chapter 4 with regard to the principle governing collaboration between doctors and non-medical psychotherapists. It also confirms the concept of psychotherapy as an interdisciplinary (interprofessional) service which should not be associated with medicine per se, and not at all with general practice per se, as it now is by OMSIP. Further, it confirms the view that physicians and medical specialists other than psychiatrists are not, as such, adequately prepared to supervise the diagnostic and therapeutic work of non-medical psychotherapists.

The argument of this chapter supports the view that it is *very* unlikely that medicine (general and family practice, and psychiatry) will ever be able to provide quantitatively and qualitatively adequate mental health services equitably to those in need. A major role of general practitioners and non-psychiatric specialists in substantially improved mental health resources would appear to be that of the source of referral to, and medical collaboration with, non-medical psychotherapists.

Despite the obvious merits of OMSIP, which should not be lost in any modification of its provisions, as A. H. Leighton, an eminent American psychiatrist, said, "What we now need is good five dollar psychotherapy."

Chapter 6 Psychoanalysis

Current Nature and Scope of Psychoanalysis in Ontario

There are nineteen psychoanalysts in Ontario. Of these thirteen are located in Toronto, one in Kingston, one in Ottawa and four in Hamilton. Perhaps no more than thirteen or fourteen of them are full-time or nearly full-time therapists in private practice. Three psychoanalysts (Boag, Hunter and Epstein) are chairmen of Departments of Psychiatry (at Queen's, Toronto and McMaster universities respectively). Most, if not all psychoanalysts, commit part of their time to the education of other mental health professionals, especially psychiatrists. Because of the privacy it offers, private practice is found by most psychoanalysts to be the best environment for psychoanalysis. They treat severely disturbed neurotic patients, for the most part, on an intensive long-term basis (four to five sessions per week of one-hour duration for periods of two to five years).

Although Ontario has only nineteen psychoanalysts, the rate of increase has accelerated sharply in the last ten years. In 1954, when the Canadian Psychoanalytic Society was being formed, Ontario had only one psychoanalyst. However, the psychoanalysts interviewed estimated that there is a need for approximately 100 psychoanalysts in Ontario for front-line therapeutic work, to which may be added those who are needed for administration, research and teaching.

The prospects for the future are brightened by two factors. There are sufficient numbers of training analysts in Ontario to mobilize a training program for psychoanalysts in Ontario. The program will get under way in the autumn of 1969. (In order to qualify as a training analyst, a psychoanalyst must have been a member of the Society for five years and have passed a special examination or have achieved equivalent standing in a Society or Association recognized by the International Psychoanalytic Association.) Prior to this new development for psychoanalysis in Toronto and Hamilton, the only centre for psychoanalytic training in Canada has been Montreal.

An Historical Note

Psychoanalysis has occupied, and continues to occupy, a crucial place in mental health, for essentially two reasons. First, by his discovery of psychoanalysis, Freud placed therapeutic psychology on a scientific footing for the first time and simultaneously created a new therapeutic technique. Freud's method of free association provided both a new method of observing the underlying forces that determine human personality and behaviour, and a treatment method that proved

efficacious in the resolution of neurotic disorders.¹ Freud's discoveries lie at the origin of the immense development of psychodynamic therapies in psychiatry and psychology during this century. Second, Freud found psychoanalysis to be essentially an interdisciplinary science and an interprofessional diagnostic and treatment service. Therefore, in principle (although not, unfortunately, always as a matter of historical fact) psychoanalysis can function as the foundation for the necessary theoretical, practical and professional intercommunication and cooperation between medicine and the non-medical disciplines that is so much needed at every level and in every aspect of mental health.

Contributions of Psychoanalysis to Mental Health

Psychoanalysis appears to make three basic contributions to mental health. First, it provides the most essential component of the theoretical foundations of all aspects of psychological medicine. Consequently, it has an important teaching function in relation to all of the mental health professions. Second, it provides a scientific technique for making psychodynamically significant observations by means of which further theoretical and practical knowledge can be gained. Consequently, it has an important research function. Third, it provides a special type of psychological therapy for the treatment of severe psychoneurotic disorders. Thus, in varying degrees, psychoanalysis is essential to psychiatry, clinical psychology, psychiatric social work, and the psychiatric component of family medicine. However, psychoanalysis is itself a distinct and separate discipline, and it is practised by a distinct and separate profession. This fact is not well understood even by the university-educated public.

Misconceptions about Psychoanalysis

There are two prevalent confusions concerning psychoanalytic practice and the psychoanalytic practitioner. Some people believe that anyone who is a psychiatrist is also a psychoanalyst and competent to psychoanalyze a patient; others believe that any non-medical person who is involved in psychological counselling and who listens to a client's intimate, emotional self-revelations is practising psychoanalysis. Neither of these ideas is correct. The fact that they are prevalent is a clear indication of the confusion in the public mind about psychoanalysis and the specific scientific and therapeutic resources it has to offer.

This confusion is not always limited to the public. Some psychiatrists cooperate with it by failing to make clear to their patients the difference between psychotherapy and psychoanalysis, and by failing to always make it clear that a psychiatrist, per se, has not been trained to perform psychoanalysis. The confusion is encouraged also by non-medical professionals, such as psychologists and social workers, who in their work with patients cooperate passively or actively with this

¹F. Alexander, M.D. and Helen Ross, *The Impact of Freudian Psychiatry*, Doubleday, New York, 1961, pp. 1-33.

misunderstanding. The fact is that a psychiatrist, a physician, a psychologist or a social worker may be a psychoanalyst; but in order to be a psychoanalyst he must have undertaken a highly specialized, intensive training program and have mastered a specialized treatment and research technique. Anyone, including a psychiatrist, who attempts to practise psychoanalysis without such training is acting irresponsibly and inappropriately.

The situation in this respect appears to be much better in Ontario than it is in the United States. A United States survey of psychiatrists revealed that many more psychiatrists claimed to provide psychoanalytic treatment to their patients than were psychoanalytically trained. In contrast, among the respondents to the questionnaire sent to Ontario's psychiatrists (Study 2) in connection with this report, there were only two psychiatrists who reported treating patients by means of psychoanalysis who did not also report having received psychoanalytic training. The field research did not uncover any cases of qualified social workers or registered psychologists who were attempting to practise psychoanalysis. Some evidence of untrained persons claiming to practise a form of psychoanalysis was presented, but could not be verified because the individuals in question refused to be questioned on matters of practice or training.

Nevertheless, psychoanalysts in Ontario have consultations, from time to time, with patients who believe that they have been receiving psychoanalytic treatment from a psychiatrist, psychologist or other person, who, it turns out, is not trained to carry out psychoanalysis. Psychoanalysis is the most intensive form of psychological therapy. In the hands of a skilled therapist it can bring great benefits to persons who are handicapped by severe psychic disturbances. In the hands of an incompetent it can do damage. With the advent of OMSIP it becomes all the more important that the public be fully aware of the nature of different specialties and the services they can render, if these services are to be responsibly used by people in need of help.

A Terminological Problem

Central to the question of licensing psychoanalysts, there is a terminological problem that reflects a substantive issue. There are a variety of different "psychoanalytic" theories with different approaches to treatment derived from them. Adler, Jung, Binswanger and others have all adopted the term to describe their theoretical postulates and therapeutic procedures. Consequently, the question arises when one is considering legislation on licensing as to what group or groups should be entitled to use the term and to be publicly recognized as legal practitioners of the therapy. There are decisive arguments for granting Freudian psychoanalysts exclusive right to its use: 1) Freud invented the term and applied it to a specific theory and a specific therapeutic procedure; 2) this theory and therapy with modifications and additions made in the light of further observations, but without the basic departures of psychologists or psychiatrists such as Adler, Jung or

Binswanger, has been adopted and is being practised by large numbers of Freudian analysts throughout the world and in Canada.

This question was thoroughly investigated by a special committee of the British Medical Council which reported in 1923. In the years that have intervened since that report, nothing fundamentally new has arisen to alter the situation. Existential psychoanalysis has been invented and the term "psychoanalysis" has undergone further expansion of use, but the principle at issue is the same now as then. The essential finding of the Psychoanalysis Committee was as follows:

Psychoanalysis is a term now used in two ways:—

(i) in a loose popular sense hardly capable of description or definition so wide is its extension.

(ii) in the strict sense of the technique devised by Freud, who first used the term, and the theory which he has built upon his work.

It is accordingly recognized that in any scientific enquiry into the matter the claims of Freud and his followers to the use and definition of the term are just and must be respected.²

This report has found no convincing reason to modify or alter the finding of the British Medical Council.

The Licensing of Psychoanalysts

The licensing of psychoanalysts requires an examining, certifying and licensing body. The distinct nature of psychoanalysis dictates that psychoanalysts and *not* any other mental health professions form such bodies. A psychoanalyst may be, but need not be, a psychiatrist; conversely a psychiatrist need not be, but may be, a psychoanalyst. Psychiatry is a medical specialty, whereas psychoanalysis per se is not, because a psychoanalyst need not have any medical training. Some of Ontario's psychoanalysts are certified psychiatrists; others have come to psychoanalysis via some other medical specialty; yet others are physicians without a medical specialty at all; and one has a background in clinical psychology. Training in psychiatry is not deemed to be a prerequisite for psychoanalytic training, and psychiatric training and qualifications are so different from their psychoanalytic counterparts that no psychiatrist, per se, would be in a position to fulfil the responsibilities involved in examining, certifying, and accrediting psychoanalysts. Moreover, some psychiatrists have a hostile disposition towards psychoanalysis (Table 4.4) grounded in or rationalized by the organicist hypothesis.³ This hostility is shared by some psychologists as well. These attitudes will be examined in more detail subsequently, but their existence requires that any legislation establishing examining and certifying institutions should be based on the recognition that psychoanalysis is a distinct and separate profession which can be properly regulated only by itself.

²The Supplement to the British Medical Journal, Appendix II, June 1923, p. 270.

³*Ibid.*, p. 5. For a detailed statement of some of the basic theoretical and therapeutic issues see also, *ibid.*, pp. 262-270.

A second consideration is, if anything, more important. Psychiatry is a medical discipline, whereas psychoanalysis is not. Psychoanalysis was discovered by a physician, but its discoverer did not find psychoanalysis to be theoretically or technically dependent on medicine except in one specific respect. Freud formulated the distinction between medicine and psychoanalysis essentially as follows:

- 1) The basic concepts and hypothesis upon which the science of psychoanalysis is built are psychological rather than physiological in nature.
- 2) The method by means of which psychoanalytic hypotheses are verified or falsified — the observation of processes of free association — also is psychological.
- 3) Psychoanalytic treatment does not involve the use of drugs or any other physical instruments or procedures; on the contrary, it is based on an exchange of information between patient and analyst in the context of a specific psychological relationship.
- 4) Psychoanalysts should have some medical knowledge, but they also need to be knowledgeable in such fields as cultural anthropology and literature, which form no part of the medical curriculum.

The one point at which psychoanalysis and medicine are necessarily interdependent is in the diagnosis of disorders 1) when it is necessary to determine what, if any, role organic determinants may be playing in the causation of psychological symptoms; and 2) when there is a concomitant physical illness. The need for a differential diagnosis arises in the most obvious way prior to treatment, since treatment must be based on it; but it may arise again during the course of treatment. The only person competent to perform a differential diagnosis of this kind is a physician. Freud points out, however, that it is not in the best interests of the analysis of a patient if, when the need for an investigation of possible organic determinants of an illness arises during treatment, the physician analyst performs the investigation himself, even if he is qualified by training to do so. Additionally, the referral of a patient in such circumstances to a non-analytic physician would act as a safeguard against any tendency in the analytic physician to underestimate organic determinants of the illness. Consequently, Freud took the view that even when the analyst is medically trained, the specific demands of his analytic work require the maintenance of a differentiation in practice between psychoanalysis and medicine.⁴ For these interrelated reasons Freud stated that psychoanalysis is not a medical specialty. It is a distinct body of psychological knowledge linked to medicine and, in a very special way, to psychological therapies in psychiatry. But psychoanalytic knowledge also has applications to clinical psychology, psychiatric social work, and education. And it has theoretical applications in the humanities and social sciences. Any legislation concerning the training and licensing of psychoanalysts should take these facts fully into account.

⁴S. Freud, *The Question of Lay Analysis*, University of Chicago Press, Chicago, 1964.

Historical Relationship Between Psychoanalysis and Medicine

The considerations above are more theoretical than historical. Historically, the development of the relationship between psychoanalysis and medicine has not always followed the path recommended by Freud.

In the United States

In the United States medicine took possession of psychoanalysis. The American Psychoanalytic Association will not train anyone who does not hold a medical degree to practise psychoanalysis as a therapist. Non-medical analysts are trained, but their applications of their analytical training must be restricted to theoretical work and teaching. No non-medical analyst who is a member of the American Psychoanalytic Association may diagnose or treat anyone suffering from any type of mental illness.

A senior Canadian psychoanalyst has pointed out an anomaly in the situation produced by this regulation. In order to become a psychoanalyst, it is necessary to undergo a personal analysis. This analysis is called a training analysis, but the training analysis usually has to take the form of a personal analysis designed to correct psychopathology in the trainee. In other words, such analyses are usually therapeutic as well as didactic. The training analysis may be conducted by a senior non-medical analyst, some of whom are among the most expert analysts in the United States. Thus, a person who is accepted as having the superior qualities required of the analyst who trains other persons to treat patients is, nevertheless, debarred from treating patients himself. According to the American analysts interviewed, the principal reason for the decision of the medical analysts in the United States to establish a monopoly on psychoanalysis (as a treatment) was the existence and increase of psychoanalytic quacks who were seen as endangering the public and the reputation of psychoanalysis.

The view of the relationship between psychoanalysis and medicine on which the American Psychoanalytic Association is based has not gained recognition in legislation, and in several places psychoanalytic training institutes have been formed which train medical and non-medical persons to perform psychoanalysis. An example of such an institute is the William Alansen White Institute in New York. Its Fellows and training and supervising analysts include both M.D.'s and Ph.D.'s. They provide a Certificate Program in Psychoanalysis which is open to qualified psychiatrists and qualified psychologists with a Ph.D. degree in clinical psychology. The William Alansen White Institute, affiliated with the American Academy of Psychoanalysis, was established in 1964 under the New York State Educational Law as a non-profit Educational Corporation. It has associated clinical services that provide psychoanalysis, psychotherapy, social work counselling, and a diagnostic service for the early detection of learning disabilities. The clinical services have been approved by the New York State Department of Mental Hygiene. The existence of other Institutes that offer a much lesser quality

of training than does the William Alansen White Institute, and in which medical analysts have no real involvement, provides a strong argument against the American pattern; for it has created a situation that favours rather than discourages the growth of maverick and quack training institutes and clinics.

In Canada

The development of psychoanalysis in Canada has followed a different pattern based on the principles set down by Freud. The Canadian Psychoanalytic Society was incorporated in 1955. In 1957, under the sponsorship of the British Psychoanalytical Society, it became a Component Society of the International Psychoanalytical Association. As a result of this affiliation to the International Psychoanalytical Association, the Canadian Psychoanalytic Society acquired the responsibility of regulating the practice of psychoanalysis in Canada and of training Canadian psychoanalysts. From its inception in Canada the major centre for psychoanalysis has been Montreal. In 1954 the Department of Psychiatry in McGill University's Medical School sponsored a provisional psychoanalytic training program. In 1957 a Committee on Education was established to decide on matters of curriculum and on regulations relating to psychoanalytic training. Finally, in 1960 the Canadian Psychoanalytic Society established the Canadian Institute of Psychoanalysis. The responsibility for the training of psychoanalysts in Canada was delegated to the Institute by the Society; the Society retains the responsibility for regulating the practice of psychoanalysis.

The principle upon which the Institute selects candidates for training is contained in the statement of Prerequisites for Candidates in the Institute's calendar.

While the Institute reserves to itself the right to accept for training candidates with exceptional gifts outside the formal academic standards, admission is usually restricted to candidates who hold a degree in medicine or a relevant subject (psychology, education, nursing, sociology, humanities, etc.) and who, by their work in the field of their activity, have shown indications of developing an increasing interest in the relationship of individuals.⁵

This statement is premised on the assumption that psychoanalysis is an interdisciplinary science for the understanding and practice of which medicine is not a *necessary* prerequisite. Medicine is a *possible* prerequisite, along with other academic and professional disciplines, psychological and social sciences, and humanities.

Advantages of the Canadian Approach

In one respect the training of psychoanalysts is uniquely the concern of psychoanalysts, since they are the only persons who are sufficiently knowledgeable to have an *informed* concern. Public interest arises, however, when an essential public service is at issue, as is the case with psychoanalysis.

⁵*Canadian Institute of Psychoanalysis Training Programme*, p. 3.

This interest clearly supports the principles of psychoanalytic training as it is now constituted in Canada. First, American experience has demonstrated that the exclusive supervision of psychoanalysis by medicine has not inhibited the growth of maverick psychoanalytic groups which provide a lesser, an inadequate, or a deleterious service to the public; nor has it prevented the practice of psychoanalytic quacks. Second, at a time in the development of society when there is a greater need for psychoanalysis than can be provided by the practitioners now available, it is undesirable to draw professional resources exclusively from the medical profession, which is already in dangerously short supply, unless medical expertise is absolutely essential to it. As has been shown, this is not the case. To be sure, it is desirable that many psychoanalysts have medical training; but it is not necessary, and it is undesirable, according to Freud, that *all* should. Recruitment of suitable persons from non-medical disciplines and professions would have the obvious social advantage of increasing the mental health resources of the province without drawing on badly needed medical services. Third, the overall long-term advancement of society and the well-being of people depends largely on the growth of knowledge and its progressive application to the problems of life and living. Consequently, it is important that psychoanalytic knowledge become increasingly available to people in a variety of scientific and educational contexts. Such a development will be served best by the active involvement of non-medical professionals in the advancement of psychoanalysis, and in its application to individual and collective human problems. For these reasons it is important that any legislation bearing on psychoanalysis should not alter the course of development on which psychoanalysis has embarked in Canada under the auspices of the Canadian Psychoanalytic Society and its training institute.

Formal Relationship Between Psychoanalysis and Medicine

How does psychoanalysis as practised in Canada cope with the crucial problem of differential diagnosis and the necessity of its being performed by a physician? The principle governing the practice of non-medical analysts is set out in the calendar of the Psychoanalytic Institute under a paragraph entitled "Obligation". It is of such importance to a basic issue of the entire report that it is quoted in its entirety.

All students are required to sign an obligation not to call themselves or permit themselves to be advertised as being psychoanalysts until they have completed the course of training to the satisfaction of the Training Committee. Before a non-medical person is accepted for training, he is required to pledge himself never to, nor claim himself to be competent to, diagnose the nature of a person's illness or to advise treatment by psychoanalysis; and following election to membership to treat only those patients by psychoanalysis who are referred to him for psychoanalytic treatment by a licensed medical practitioner, with whom or with whose successor, he promises to co-operate during the duration of the treatment.⁶

⁶*Ibid.*

This regulation spells out clearly the nature of the relationship to medicine and medical expertise that makes it possible for a non-medical practitioner to bring the benefits of psychoanalysis to the public, while at the same time maintaining the safeguards that medicine alone can provide. The practice rests on the cornerstone of interprofessional cooperation and an appreciation of limits of competence. The principle used by psychoanalysis to regulate the relationship between medical and non-medical practitioners within psychoanalysis is one that can be usefully generalized to the other areas of mental health. In particular, as suggested in Chapter 4, the psychoanalytic regulation provides a model for a working relationship between physicians and non-medical psychotherapists.

Psychoanalysis as a Medical Specialty

Because of its interdisciplinary nature, it would be inappropriate for psychoanalysis to become a medical specialty in exactly the same way in which psychiatry is. On the other hand, it is a therapeutic specialty of equal stature with psychiatry by any scientific, training, professional or service criteria. Consequently psychoanalysis should be recognized as a specialty on an equal footing with the medical specialties, but altogether independent of them.

It is desirable to have a procedure whereby any *physician* who is also a *qualified psychoanalyst* could be accredited as a *specialist* by the Royal College. But any formula for achieving this objective should safeguard the independence of psychoanalysis with respect to the training and regulation of psychoanalysts and the right of any psychoanalyst, whether or not his background is medical, to practise psychoanalysis. It is correspondingly desirable to have a procedure whereby any *physician* who is also a *qualified psychoanalyst* can be licensed as a medical specialist in Ontario.

Psychoanalytic Education and Training

Psychoanalytic education is, at the moment, a completely private matter, legally, institutionally and economically. There is no statute establishing a psychoanalytic training institute in Ontario; the first training program in Ontario has been organized only recently. No public funds support psychoanalytic education.

This situation has certain inherent advantages. When it is organized privately, psychoanalytic education cannot be hampered by the bureaucratic inertia and philosophical fixations of tradition-bound universities. The public is spared the burden of subsidizing the training of a professional group. The individual who is receiving psychoanalytic training arranges for training analysis and case supervision on a private contractual basis with a training analyst; seminar and lecture courses are provided by the Canadian Institute of Psychoanalysis. Student fees cover the administrative and teaching costs involved; thus, the cost of training is borne entirely by the student. This cost is in the range of \$25,000 to \$30,000 per student. The major cost is the training analysis, which costs about \$25,000.

Similarly, because of the special nature of psychoanalytic research (research and therapy coincide), the advancement of knowledge in this field is subsidized, except for trivial amounts, by psychoanalysts themselves and by their patients from whom they receive payment for treatment.

Some disadvantages may accrue from the existing system. Psychoanalysis is unlikely to have the full impact it should have on the faculties of medicine and the arts and science faculties, if psychoanalytic education remains entirely outside the universities.

To be sure, this disadvantage does not affect medicine quite as directly as other university faculties. As has been already pointed out, for some time, psychoanalysts have been making substantial contributions to psychiatric training. It may be that the advantage of independence without its disadvantages can be maximized in this way as far as the medical faculties are concerned. But because of the isolation of medicine from the humanities and social sciences, it is unlikely that psychoanalysis will have the impact throughout the university that it should have, if it is permanently limited to medicine via psychiatry. The same approach might be taken to the humanities and social sciences by the appointment of psychoanalysts to other university departments. A step in this direction has been taken at the University of Toronto with the appointment of I. Schiffer, one of Toronto's leading analysts, to the Department of Political Economy.

The cost of psychoanalytic education in the absence of public support acts as a deterrent to the recruitment of trainees and exerts a strong pressure against non-medical analysts. In order to shoulder the financial burden involved, a student must either be independently wealthy or have already established a highly successful professional career. But this very condition is a deterrent to undertaking the further step of psychoanalytic training by those who might otherwise be interested, once they have the means to do so. Furthermore, a highly successful professional career as measured by earnings is much more readily available to the medical practitioner than to most other professionals. Consequently, the absence of public support for psychoanalytic education creates a strong pressure against the recruitment of non-medical professionals to psychoanalysis.

Although basic psychoanalytic research is conducted only through the psychoanalysis of persons using the technique of free association, there is, in addition, the rapidly expanding field of general public education in psychodynamics and personality development, and the application of psychoanalytic discoveries to the social sciences and the humanities. Leadership in this area of psychoanalytic education and research in Ontario has been given by I. Schiffer, through the establishment of the Toronto Psychoanalytic Forum of the Humanities. The Psychoanalytic Forum has open meetings during the academic term. The meetings — attended by social scientists, humanists, psychiatrists, psychologists, theo-

logians and interested members of the public — take the form of informal research and discussion seminars. Again this development is a private undertaking at private cost.

Is there any new type of development that might resolve some of the difficulties and limitations inherent in the present situation? One possibility would be the formation of University Centres for Psychoanalytic Studies to which psychoanalysts could be appointed. These centres could be formally independent of both the medical faculties and faculties of arts and science, but related to them by providing instruction in psychoanalysis as needed by students in these and other university faculties (such as social work and law). They could function also as training centres for candidates in psychoanalysis and centres for psychoanalytic research. The incorporation of psychoanalysis into the university communities in this way would be likely to have numerous reciprocal scientific and educational benefits.⁷ It would create a mechanism for the provision of public funds for psychoanalytic education and research, and thus bring about equity of treatment vis-à-vis other professional training programs (such as psychiatry and clinical psychology) which are now publicly supported. It would help remove the financial cause of the privileged access of medical practitioners to psychoanalytic training and thus facilitate the growth of psychoanalysis in the direction of a truly interdisciplinary mental health profession. This could do much to foster the kind of cooperation between medical and non-medical professionals that is desperately needed in the field of mental health.

Extent of Non-medical Psychoanalysis in Ontario

Although psychoanalysis in Ontario is, in principle, an interdisciplinary profession involving physicians, psychologists and others, there is, in fact, only one psychoanalyst in Ontario who is not a medical doctor. D. L. Bhandari, a Ph.D. in psychology and a registered psychologist as well as a psychoanalyst, is in charge of diagnostic psychological testing at Queensway General Hospital where he also does some individual and group psychotherapy. He conducts a part-time private practice. Dr. Bhandari received his training in psychoanalysis in England.

There appear to be three factors that will act in resistance to the needed increase in the number of non-medical psychoanalysts. First, there is some reluctance on the part of Canadian psychoanalysts to train non-medical analysts, in part because (other qualifications being equal and training facilities being limited) a medically trained candidate is preferred; and in part because a few Canadian analysts share the opinion of their American colleagues that non-medical analysts should not be permitted to treat patients. Second, there is a general resistance to non-medical analysts among doctors based on ignorance, a monopolistic attitude towards healing services, and prejudice against psycho-

⁷Freud has pointed out these benefits in his article, "On the Teaching of Psycho-analysis in the Universities," *Standard Edition*, Vol. XVII, p. 173.

analysis. This resistance limits the number of referrals to a non-medical analyst. Because of the condition under which he must practise (which has already been discussed above), the non-medical analyst is dependent on the knowledge, goodwill and cooperation of physicians. Physicians, in general, are not remarkable for any of these qualities as far as psychoanalysts are concerned, medical or non-medical. Third, medical practitioners have been granted a monopoly on the province's publicly supported medical insurance plan. Under it, psychoanalytic treatments are insured only indirectly and not as such, since they come under the generic category of psychotherapy. The amount of insurance coverage is based, not on training qualifications and the nature of the service, but on the professional classification of the practitioner. Thus, if the practitioner is a specialist in psychiatry, his psychoanalytic treatments are insured at the specialist rate; if the practitioner is a physician but not a psychiatrist, his psychoanalytic treatments are insured at the general practitioner's rate, which is less; if the practitioner is not a physician, his psychoanalytic treatment is not covered at all. Clearly, the non-medical psychoanalyst is placed at a real disadvantage relative to other psychoanalysts, since his patients are denied the benefit of the insurance scheme, even though from a scientific point of view there is *no* difference in the nature of the service received.

These factors will inhibit the growth of a strong corps of highly skilled non-medical psychoanalysts.

Anomalies in the OMSIP Provision Concerning Psychoanalysis

It is worth pausing to consider some of the anomalies inherent in the OMSIP coverage for mental health services which arise from its being based on professional rather than scientific principles. There are at least three. First, a general practitioner or a psychiatrist who has no psychoanalytic training could undertake to give psychoanalytic treatment and be remunerated for it by OMSIP, although he would be engaging in quackery, while the patients of a fully trained and seasoned non-medical psychoanalyst are not insurable under the scheme. Second, the service of a qualified physician psychoanalyst are covered under OMSIP in the same way as counselling or psychotherapy done by a general practitioner who is not trained to do either. Third, the psychotherapeutic services of a psychiatrist, who may have had no psychodynamic training at all, are covered under OMSIP at the specialist's rate; whereas the services of the physician psychoanalyst who is not a psychiatrist, but has received a highly specialized training in psychodynamic therapy, are classified as non-specialist along with the general practitioner's and are covered at the general practitioner's rate. The genesis of these anomalies is no doubt to be found in a perennial inadequacy in bureaucratic thinking: its tendency to be influenced by tradition and powerful vested, and in this case, professional interests, rather than in need, reality, science and a consideration as to how these can be most effectively and economically united in service to benefit people in need. All of these anomalies require

correction. To correct them two steps would be required: 1) the recognition of psychoanalysis as a medical specialty when practised by a physician; 2) insurance coverage of psychoanalysis whether provided by a physician or non-physician psychoanalyst. These steps would also increase the number of psychoanalysts in Ontario.

Attitudes to Psychoanalysis

Psychoanalysis is the object of highly polarized attitudes. In Ontario attitudes of antagonism or indifference have predominated. This is in sharp contrast with American and European views. For example, in the United States, for many years psychoanalysts have had a prominent teaching and training role in some of the best medical schools, such as Columbia, Yale and Harvard. (Residents in psychiatry at the New York State Psychiatric Institute take it as a matter of course that they will undertake a personal psychoanalysis as part of their preparation for work in psychiatry, and a substantial number go on to complete psychoanalytic training.) A comparable influence of psychoanalysis in Ontario's medical schools has only recently begun to take root.

There is considerable antagonism or indifference to psychoanalysis among psychiatrists, especially among institutional psychiatrists. Reasons for this attitude vary from individual to individual, but the most prevalent seem to be based on the theory that the sufficient cause of any mental disorder is organic and can be effectively treated by physical means.

These attitudes appear to be caused by one or more of the following:

- 1) Ignorance of even the elementary hypotheses of psychoanalysis.
- 2) Professional hostility and resentment towards medically trained people who have abandoned a "medical model".
- 3) The wish among psychiatrists to gain full recognition for psychiatry as a medical specialty by the traditional prestigious specialties such as surgery and internal medicine, based on the belief that the way to achieve this is to make psychiatry as much like them as possible.
- 4) Concern about the amounts of time and money absorbed by psychoanalytic treatment.
- 5) Opposition to the middle class bias of psychoanalysts in terms of patient selection.
- 6) Concern that an intensive treatment method such as psychoanalysis is of peripheral importance in the efforts being mobilized to cope with the large numbers of people in need of help.

Many psychologists also hold psychoanalysis in low regard. They oppose it on many of the same grounds as psychiatrists, but psychologists have professional reasons of their own. Some psychologists believe that their own forms of treatment are more efficacious than those used by the analysts — quicker, cheaper and

available to a broader range of patients. Others claim to have a greater range of possible treatments, such as behaviour therapy, and individual and group psychotherapy. Correspondingly, some psychologists are critical of the theoretical and methodological basis of psychoanalysis, claiming that learning theory and the principles of experimental psychology are scientifically and logically superior to psychoanalysis.

The existence of these conflicting attitudes and views will not be new to anyone who is familiar with the field of mental health. They are cited here for the purpose of emphasizing the importance of maintaining an open environment in which the facts, through accumulated observations, can decide the theoretical issues involved in a rational way. This condition can be best achieved if no single theoretical position or professional group is given special advantages or disadvantages vis-à-vis others.

The effects of this interprofessional rivalry are diverse. They range from such undesirable results as the discouragement from seeking psychoanalysis of patients who might benefit from it, to healthy competition that energizes efforts to make therapy successful, and to develop better theoretical orientations and therapeutic procedures.

In any case, the undesirable consequences cannot, in the nature of things, be regulated by an authority external to the professions themselves. Two steps will, indirectly and in the long run, bring about improvements: 1) the better education of the public concerning the different methods for treating mental illnesses and the professions that are competent to dispense them; 2) equality of opportunity among the professions for developing and dispensing the services within their competence. The first will reduce the extent to which needy persons are uncritically dependent on advice and exhortation by professionals; the second will reduce the extent to which the members of one profession feel threatened by another and will help to create the conditions that are necessary for that mutual respect and cooperation which are in the best interests of everyone concerned, especially of the public.

More positive attitudes towards psychoanalysis exist. Most psychiatrists and psychologists who are critical of psychoanalytic therapy, but have some familiarity with psychoanalysis, acknowledge that psychoanalysis has a major contribution to make to the teaching of psychodynamics, which is the theoretical basis of psychotherapy. Indeed, as psychiatrists come to be better prepared in psychodynamics it is likely that the contributions of psychoanalysis to psychiatry will be more appreciated. The same applies to clinical psychology. This prediction was suggested by a sharp contrast found between the impressions formed in field interviews and the results of the questionnaire survey.

The field interviews were conducted for the most part with Department of

Health psychiatrists or psychiatrists practising in General Hospitals. The overall impression generated by these interviews was that of a pervasive attitude of indifference or hostility to psychoanalysis. (No doubt a major determinant of this attitude is the fact that the vast majority of illnesses seen in such practices are psychotic; and many psychoanalysts would agree that psychoanalysis, while it is helpful in understanding the formation of psychotic symptoms, is not particularly efficacious in treating them.) Consequently, the results of the questionnaire to psychiatrists were rather surprising. One of the questions raised was "Is there a need for psychoanalytic training in Ontario?" Of the responses, eighty-eight were affirmative, fifty were negative, and eleven were uncommitted. The explanation of this difference between the results of the field interviews and the questionnaire survey would appear to lie, as already suggested, in the nature of the psychiatrist's practice; in the types of problem he is, for the most part, confronted with; and in the treatment techniques he employs. The more the psychiatrist deals with neurotic disorders by means of psychotherapy, the more likely it is that he will come to appreciate the importance of psychoanalysis. In general, psychiatrists in private practice treat mainly neurotic disorders by means of psychotherapy. The questionnaire was sent to all psychiatrists, including those attached to institutions as well as private practitioners. Among the respondents there were forty-three psychiatrists who devoted 40 per cent or more of their time to private practice; of these, thirty were affirmative concerning the need for psychoanalytic training in Ontario and thirteen were negative. The respondents who devoted less than 40 per cent of their time to private practice were thirty-four affirmative and twenty negative. All eleven of the respondents under thirty-one years of age thought that Ontario needs a psychoanalytic training program.

Therapeutic Contribution of Psychoanalysis

It is a generally accepted view among psychoanalysts themselves that psychoanalytic treatment is best suited for the treatment of severe psychoneurotic disorders. Psychotic illnesses, for the most part, are not benefited substantially, and mild neurotic disorders can be helped by less intensive and time-consuming psychotherapy or counselling, depending on whether the problem is essentially psychogenetic or environmental. Consequently, psychoanalytic therapy is one of a number of different essential therapeutic services needed by the province in order to serve the mental health needs of its population. The special contributions of psychoanalysis — contributions which justify the word "essential" — appear to be two-fold: first, psychoanalytic treatment can benefit the most severe and disabling psychoneurotic disorders; second, it can do so without the aid of drugs, physical treatments or hospitalization and, hence, without disruption of the patient's personal and occupational life. It is for this reason, as well as the economic one, that the patients of psychoanalysts tend to be businessmen, professional people, and persons in public life who cannot afford to be out of action, and whom society cannot easily afford to have out of action.

Some analysts, because they appreciate that they are unable to treat many patients, will select the patients they take into treatment, in part on the basis of the indirect benefits to society accruing from the successful analysis of the patient. In this way analysts are seeking to further the general aim of community psychiatry which is to create a healthier social environment. If persons in positions of leadership in the professions, in education, business and public service are both mentally healthy themselves and perceptive of the factors making for mental well-being, this aim will become more attainable.

Conclusions

There is a need for some form of psychoanalytic licensing body in Ontario. It would appear that the principles governing the formation of such a body should include at least the following:

- 1) The status of psychoanalysis as a distinct profession should be fully recognized.
- 2) Reciprocity of certification between Ontario and other Canadian provinces should be established by recognizing the Canadian Psychoanalytic Society as the certifying body for all psychoanalysts in Ontario. This would prevent the provincialism and fragmentation that now exists in psychiatry, to the detriment of that profession.
- 3) The interprofessional character of psychoanalysis should be formally acknowledged.
- 4) The conditions under which psychoanalysts without medical training treat patients should be explicitly stated and adopted.
- 5) A representative or representatives of the public interest should be included in such a body in a minority position.
- 6) No monopoly on psychoanalytic diagnosis, treatment, research or education should be granted to medicine.
- 7) Professional reciprocity between psychoanalysis and medicine should be established such that a medical practitioner who is a certified psychoanalyst should acquire, thereby, the status of a medical specialist.
- 8) The provincial licensing body should be responsible for maintaining standards of practice and should be empowered to revoke the licence to practise when necessary; but the licensing body's decision to revoke a licence should be subject to judicial review.

Some of these principles are controversial, others are not. Concerning the second principle, in addition to the reason already given, one might include two others. Ontario is likely eventually to be called upon to export psychoanalysts to other provinces where none now exist, just as Quebec is now being asked by Ontario to relinquish some of her psychoanalysts in the interest of growth in Ontario. The national development of psychoanalysis will be best facilitated

by a national examining and certifying body — that is, by vesting these powers in the Canadian Institute of Psychoanalysis and the Canadian Psychoanalytic Society respectively.

Through its affiliation with the International Psychoanalytic Society, the Canadian Psychoanalytic Society is in the best position to provide for the certifying in Canada of practitioners from other countries. However, the licensing of professionals is within provincial rather than federal jurisdiction. The best solution therefore appears to be composed of these three elements corresponding to the three major functional components of examining, certifying and licensing. Examining and certifying should be powers of the national bodies. Licensing should remain a provincial function. The issuance of a licence should be contingent upon, and automatic with, certification by the Canadian Psychoanalytic Society. Certification should itself be contingent upon success at examinations conducted by the Canadian Institute of Psychoanalysis. As far as Canadian-trained psychoanalysts are concerned, Ontario's psychoanalytic licensing board perhaps should be represented on both national bodies on an equal footing with representatives of other provinces, so as to be able to influence directly the standards for examination and certification of psychoanalysts. Such an institutional structure would necessitate the establishment of uniform standards of education and certification on a nation-wide basis; and it would avoid the fragmentation and inequalities in education and certification that have generated the undesirable situation in psychiatry whereby an individual may be a certified psychiatrist in Canada and be unable to receive a licence to practise his specialty in Ontario. If this structure were adopted, Ontario's psychoanalysts might well require at some time a provincially based examining and certifying body on grounds of efficiency and economy. In that case the provincial body would be exercising a power vested in it by the corresponding national bodies and would remain responsible to the national bodies.

Concerning principle five, it should be made perfectly clear that there is and has been no disregard of public interest on the part of psychoanalysts that justifies their being singled out as requiring a public representative on their licensing body. On the contrary, psychoanalysis has asked for nothing from the public purse and has contributed not a little to public well-being. Nor should this proposal be recommended in relation to psychoanalysis if it is not recommended in relation to all other professions. The principle is introduced here only because the discussion provides a suitable context, but it should be viewed as having either universal application or no application at all.

Psychoanalysis itself emphasizes the importance of reality testing, and the worth of independent interpretations of the meaning and consequences of privately motivated decisions. Such a function could be performed by sympathetic individuals of recognized stature in other fields or disciplines who could view decisions concerning licensing policy-making and policy implementation from a non-

professional and, perhaps, more external point of view. The formal inclusion of such a point of view in the exercise of these powers is especially important when the granting of these powers is tantamount to the granting of a monopoly on the services in question. In the continuing availability and quality of these services — whether they be psychoanalysis, psychiatry or clinical psychology — the public has a continuing and legitimate interest. This may not be the case with other professional matters, but it is the case with the exercise of examining, certification and licensing powers. These are essentially a public trust to be exercised by a profession in the best interests of the public, rather than for the profit of the profession alone.

The opportunity to locate a training program in one of the universities of Ontario as part of a Centre for Psychoanalysis should be available to Ontario's psychoanalysts. The criteria for the location of such a centre should include a sufficiently large number of psychoanalysts in the vicinity of the university and a medical faculty at the university. By these criteria the University of Toronto might qualify or possibly, in the future, McMaster University. At present Ottawa, Kingston and London would be ruled out because there is not a sufficient number of psychoanalysts in these cities.

As soon as the registration of psychoanalysts has been established on the basis of adequate licensing procedures, psychoanalytic therapy should be covered under OMSIP as a diagnostic and therapeutic specialty, whether dispensed by a medical practitioner or not.

Chapter 7 Nursing and Psychiatric Nursing

General Background and Definitions

Nursing in general is undergoing a transition as a result of a variety of factors, of which three seem to be particularly important. First, nursing is experiencing a strong pressure towards increased specialization, resulting from increased specialization in medicine. Second, the modernization and urbanization of Ontario since the Second World War has diminished the importance of the general nurse who is competent to perform a wide variety of tasks. Even the countryside is being urbanized through improvements in transportation, and this has made possible the building of larger hospital units serving larger areas. Third, the shortage of nurses has required both that the nursing skills available be used economically (that is, for performing the more specific technical, rather than the general and menial, nursing tasks) and that other subprofessional personnel be employed to perform the menial and clerical duties traditionally performed by nurses.

These pressures have been recognized and accepted by the profession itself. Curriculum changes are under consideration that will make the training of nurses more congruent with the changes in function that are taking place. Nevertheless, two basic features of traditional nursing still prevail and are likely to prevail in the future: in Ontario, nursing is essentially a woman's profession; and the nurse is the one person who is involved in all aspects of the patient's care and well-being on an hourly and daily basis during hospitalization.

In other societies, of which Great Britain is an example, nursing is performed by both men and women. In Ontario, though, it is identified firmly as a feminine activity, both socially, in terms of professional tradition, and individually, in terms of basic attitudes. Any attempt to change the profession's sexual identity is likely to meet strong and no doubt justifiable resistance.

Nurses have a different degree of involvement in different aspects of patient care. As far as treatment is concerned, their function is subordinate to that of the physician, who is responsible for it. But it is the nurse who has most contact with the patient and has a major responsibility for keeping the patient's progress under informed observation in the context of providing and supervising his general care. It is against this background that psychiatric nursing must be considered.

The term "psychiatric nurse" leads to some confusion, since the word is commonly used in three different ways. The most general use of the term, in Ontario, is in reference to a graduate nurse, registered in the province, who is

working with mentally ill patients in a hospital setting. Beyond general orientation and whatever in-service education a particular hospital happens to provide, there are no schools where a general nurse can receive advanced training in a psychiatric specialty. The term "psychiatric nurse" is also used to describe the graduates of certain training programs in the four western provinces, in Jamaica, and in Great Britain. These nurses take a training course concentrated on psychiatric illness. But they do not have sufficient medical background in fields like paediatrics or obstetrics to become registered nurses. Since there is no other term to describe this later group, it seems prudent to reserve the term "psychiatric nurse" for them, and to use the term "registered nurse" to describe the first group. A third group referred to by this term is graduate nurses who have graduated from schools which are not recognized, or who do not have the qualifications to be registered within the province. They are nurses with a general medical orientation. In a field interview one nursing authority estimated that there are approximately 5,000 such nurses in Ontario. Under the pressure of grave shortages in the profession, the Ontario College of Nursing is seeking ways of making it possible for these nurses to prepare themselves for the examinations leading to registration.

Function of the Nurse in a Psychiatric Setting

Certain of the nursing functions in a psychiatric setting are identical with those of nurses on a non-psychiatric ward. These are 1) the supervision (and/or provision when subprofessional staff are not available) of the general care of the patient; 2) the dispensing of drugs being used in the treatment; 3) the performance of routine medical checks when they are required; 4) on-going observation of the progress of the patient and his treatment; 5) cooperation with other professional staff involved in the diagnosis and treatment of the patient in the formation of a workable treatment program. In all these respects the *function* is the same. What differs is the content of the function and the specific knowledge on which it is based. On a psychiatric ward, for example, where insulin treatments are being given, a battery of routine medical checks will be performed similar in nature and frequency to those performed by a nurse on a surgical ward; on a psychiatric ward in which the patients are receiving in-patient psychotherapy and are on a rehabilitation program without any major physical treatments, this type of medical routine will be minimized. Nevertheless, the function is the same and part of its content overlaps. Similarly, the drugs used on a psychiatric ward for the treatment of schizophrenia are different, as are the effects which must be watched for. Specific knowledge is needed by the nurse performing this task. But the general routines and procedures involved are the same as in other areas of nursing. The functions which do not overlap are the specific psychologically therapeutic roles of the nurse in the psychiatric unit or hospital. In order to understand these functions fully, it is necessary to understand a recent development in hospital psychiatry.

Milieu Therapy

Research has shown that hospitalization of a mentally ill person can itself act as a deterrent to his recovery, unless special steps are taken to provide a social structure in the hospital that preserves within it as many of the normal responsibilities and routines of daily life as are compatible with the patient's condition and the treatment of his illness. More positively, the relationships of all kinds to which the patient is subject and in which he must become involved when hospitalized can, if they are good, exert a beneficial influence upon his condition.

Milieu therapy has been developed to avoid the dangers of hospitalization. It consists essentially of conscious efforts on the part of all persons involved in the treatment and care of mental patients to provide them with dignified, healthy and satisfying relationships, and to involve them in worthwhile activities which simulate as far as possible a good social environment. Its most enthusiastic advocates see milieu therapy as a substitute for other types of psychological treatment, such as group and individual psychotherapy. A more cautious evaluation sees it as a much-needed humanization of the psychiatric ward and as an environment in which treatment can be more efficacious, but not as a form of therapy in itself or as a substitute for psychotherapy. Further experience will demonstrate its strengths and limitations. Although it is utilized rather differently, according to the estimates of its efficacy by the psychiatrists in charge and according to the professional resources available to implement it, it is now a widespread policy for the care of hospitalized patients.

The Role of the Nurse in Milieu Therapy

Because of the special nature of the nursing function in hospital settings, the major burden for the implementation of milieu therapy must rest upon the shoulders of the nurses. Implementation usually follows one of two patterns. A group of nurses works together as a team to create the desired social environment and opportunities for worthwhile activities on the ward for all the patients. Each nurse on the team shares with every other equal responsibility for all patients. Alternatively, each is assigned to specific patients for whose needs she is individually responsible. When the latter pattern is utilized, the nurse may be expected to engage in the formation of a one-to-one psychologically supportive relationship with the individual patients in her care, and to create opportunities to work with them on an individual basis. For example, if a patient continues to experience a need for personal communication after the termination of a session of psychotherapy with the psychiatrist, the nurse will be prepared to listen sympathetically to the patient and encourage him to incorporate any new insights into his problems that may be emerging. In either pattern, certain specific social and psychological nursing roles must be mastered, if the nursing is to be "psychiatric" in anything more than name only.¹ In the modern psychiatric inpatient unit these social

¹For further and more detailed discussion, see *Some Observations on the Therapeutic Role of the Psychiatric Nurse*, prepared by a Committee at the Allan Memorial Institute, J. S. Tyhurst, M.D., Chairman, May 1956.

and psychological functions are the most important ones, although they do not supplant the other more traditional, overlapping functions.

Nursing Contribution to Patient Diagnosis

Out of this specific psychiatric treatment-care function there grows an important diagnostic function for the nurse, which consists essentially of the uninterpreted reporting of her observations.

Considerable information of great diagnostic significance can be obtained by regular observations of the spontaneous relationships of patients on the ward. The voluntary associations of patients have much dynamic significance and concepts and techniques are available for their study. The kinds of social role and social relationships established by the patient on the ward are characteristic for that patient. The ward is a social system and once the range of feasible or available roles and relationships in that particular setting are known, what the patient does socially can be described and used as diagnostic data by the nurse in her contribution to the formulations made by the whole clinical team.²

Thus, there is a specific psychiatric nursing function whether one looks at it from a care, treatment or diagnostic point of view.

Psychiatric Content of Nursing Generally

It would be a serious error to suppose that these functions are *no* part of the work of nurses in other settings. Medical authorities are becoming increasingly concerned that nurses on surgical, obstetrical, paediatric and other wards are failing to meet the challenge presented by the special psycho-social patient needs that may arise with hospitalization and treatment. A review of the literature on this subject is to be found in *Teaching Psychosocial Aspects of Patient Care*, by Schoenberg.³ It is clear from Schoenberg's study how grossly deficient in psycho-social orientation and practice modern nursing has become, and how much such an orientation is needed as part of other nursing functions in every kind of hospital and clinical setting. Consequently, there does appear to be a basic functional unity linking all types of nursing activities; these activities being variegated and differentiated in terms of the specific content and the emphasis placed on one function as compared with another.

As far as psychiatric nursing is concerned, it is clear that specialized knowledge is needed in a degree of detail that would not be required in other kinds of nursing practice. Similarly, the psychiatric nurse must have sufficient self-knowledge to be able to grasp and evaluate her own psychological responses to the patients

²*Ibid.*, p. 13.

³Bernard Schoenberg, M.D., *Teaching Psychosocial Aspects of Patient Care*, Part 1, Columbia University, New York, mimeo, 1966, pp. 2-5.

in her care. A nurse working in an operating theatre may be revolted by cancerous patients; but as long as this does not interfere with the performance of her duties, it makes no difference to the quality of treatment. But a nurse working in a psychiatric unit cannot be revolted by the symptoms of a mental illness without knowing about it and being able to cope with the feelings involved, because the nurse's responses to the patient in milieu therapy form an integral part of the quality of the patient's treatment. Consequently, special orientation and training is needed for the psychiatric nurse. Similar qualities are needed in the nurse on a paediatric ward. Although they vary in the degree to which they are essential from setting to setting, some training in the psycho-social care of patients is mandatory for all nurses. Consequently, there appears to be a common core curriculum content for all nurses, an essential component of which is psychiatric training.

Two Types of Psychiatric Nursing

Although it is predictable that milieu therapy will permanently alter psychiatric nursing in the ways and in the direction just described and that it is likely eventually to have a beneficial impact on nursing generally, the role of the psychiatric nurse in Ontario's hospitals still varies along a spectrum from the traditional to the modern. In the traditional role the nurse, attired in white and wearing a starched hat with a black band, attends primarily to the physical needs of the patient and ensures that he comes to no harm. The nurse reports her observations of the patient's condition to the doctor, along with her views on the changes which have taken place in the patient's behaviour, mood and outlook. Although she might be so bold as to suggest that the patient seems to be suffering from some particular identifiable disease, she manifestly *does not* diagnose an illness, or prescribe a treatment. Although the nurse is crucial to the recovery of the patient, ideally she takes only minimal responsibility, following the direction and advice of the doctor, whom she feels to be morally, legally and administratively the only person capable of directing the patient's recovery.

The second type of nurse is dressed chicly in the latest fashion, and interrelates on personal and therapeutic levels with patients. Although these nurses too do not diagnose, they form considerably stronger opinions as to the nature of the patient's problem; and they feel qualified, when trained, to engage in individual or group psychotherapy and to aid in the therapeutic process, often without the direction of a psychiatrist. In fact, although the psychiatrist is the head of the "therapeutic team", it is possible, in the case of individual psychiatrists, for communications to break down sufficiently that the nurse is actually working at cross-purposes with the psychiatrist's treatment of a patient. In this second model the nurse is more part of the "treatment team", whereas in the first she is responsible only for providing continuous care for the patient.

Both descriptions, obviously, are extreme statements of positions which in actual practice are substantially modified in most cases. The more traditional

nurse does talk to the patient occasionally, and tries to aid in his recovery. The new model nurse will acknowledge that the patient has physical needs which may need nursing attention along with other more narrowly medical requirements relating to treatment.

It is a safe generalization that in the most advanced psychiatric centres in Ontario, Canada and the United States, the organization of inpatient care on the principles of milieu therapy is now taken for granted, because it represents an obvious improvement on the custodial and management concepts that immediately preceded it. In such centres the new model psychiatric nurse also is taken for granted, and new training programs for preparing these nurses for their work are well under way.

Nursing Education

Nursing education and training occurs according to several different patterns. The first is the traditional three-year program taught at a hospital. This combines clinical experience (in the form of using the nurse to do work without pay) with theoretical lectures. The second is what is known as the two plus one method, which involves two years of classroom experience followed by one year of straight clinical experience. The third is the two-year program such as that taught at the Nightingale School of Nursing, Ryerson Polytechnical Institute, and the Women's College Hospital. This latter method involves little clinical or administrative training, and there is some criticism of the graduates of this program who are felt to be insufficiently prepared for work in a hospital setting. The fourth method is the four-year B.Sc.N. university program.

After her basic education, the nurse is required to write a registration examination. "The nurse registration examination is in four parts — medical nursing, surgical nursing, obstetric nursing, and paediatric nursing. Each paper consists of objective type, multiple-choice questions designed to test specific knowledge and the ability to apply that knowledge in making judgments concerning the care of patients."⁴ At this time most nurses undergo a period of three months' affiliation with an Ontario Hospital, or with the psychiatric ward of a general hospital. The nurses who lack this preparation are those who have no facilities in their geographical area during training. Psychiatric knowledge is examined under general medicine.

Nurses who graduate from schools of nursing attached to Ontario Hospitals such as the one at Whitby are required to spend a period of nine months in general hospital affiliation, taking courses in general surgery, obstetrics and paediatrics. Since most of their training deals with the nursing of mentally ill patients, they are relatively better prepared to work with this sort of patient upon graduation.

⁴This is the *College of Nurses*, College of Nurses, Toronto, n.d., p. 6. Official publication of the College of Nurses of Ontario.

The views of most psychiatrists concerning the nurse's preparation for psychiatric nursing is not on the whole encouraging. One psychiatrist expressed the view that, regardless of her training, it usually took six months to break a nurse of the ingrained counter-productive habits and outlooks she had developed. The nurse's training prior to registration usually is found by psychiatrists to provide little more than a background for an informal or formal in-service training program designed to prepare her for work in the hospital.

In-Service Supplementary Training

The additional training which a nurse receives depends very much on the hospital. The fact that the hospital is associated with a university does not mean in all cases that the nurse will get a better program of in-service education. The nurse usually is provided with an orientation which lasts at most one week and at least one day. However, in the general hospitals, the orientation is to the entire hospital, and not just the psychiatric ward.

The facilities for in-service education vary tremendously, from none at all to structured programs of seminars, lectures and case discussions. To say that there is no in-service education is really an overstatement, for the nurse always attends grand rounds, at which the psychiatrists in charge explain their diagnosis of the patient's problems and indicate treatment methods. The nurse frequently benefits little from these discussions, however; sometimes they are too sophisticated for even the junior psychiatric internes. There are often staff conferences also, but the value to the nurse of these is often limited by the personality and outlook of certain doctors who are patronizing, or who are not prepared to entertain any serious questions from the nurses. Often psychologists or social workers give periodic lectures to the nursing staff, but this form of instruction depends upon the availability of personnel and their willingness to participate meaningfully in such a program.⁵

Nurses employed by Ontario Hospitals or for psychiatric services in general hospitals who lack the period of psychiatric affiliation generally are required to take the affiliation course with the student nurses before they are allowed to work for the hospital.

Evaluation of Preparation of Psychiatric Nurses

The opinion is widespread that nurses who have just graduated are inadequately prepared for work with psychiatric patients. (Field interviews with psychiatrists

⁵An impression of how much more advanced psychiatric education in nursing is in the best American centres as compared with what prevails in Ontario can be formed by reading B. Schoenberg and N. Lefkowitz, *The Integration of Psychiatry and Sociology in a Multidisciplinary Group Teaching Program*, Columbia University, New York, mimeo, 1967; B. Schoenberg and J. Schulman, "Role Strains and Adaptation in a Multidisciplinary Group Teaching Unit", *Nursing Forum*, Vol. 4 (4), No. 65, 1965; B. Schoenberg, "Consultation in a Multidisciplinary Group Teaching Program: The Counterpart Method", *Nursing Forum*, Vol. 5 (4), No. 65, 1966.

support this view.) The three-month program apparently gives the student nurse only a general impression of the exigencies of caring for psychiatric patients; and the majority of nurses are either terrified by the prospect of associating with madmen, or else look on their period of psychiatric affiliation as a relatively soft one compared to the heavier physical work of the general hospital setting. It appears that the graduates of the Ontario Hospital Schools of Nursing are much better prepared by their longer experience of working with mentally ill patients, and their exposure to both active treatment and chronic wards gives them a much better appreciation of the range of problems they will face if they choose this area as a career. Preparation for work in a psychiatric ward falls, by default, to in-service training, which is not always available in the amount or quality necessary.

No one directly connected with the preparation of this report was competent to give an independent evaluation of the adequacy of the preparation of nurses for duties in psychiatric units. To the observations and viewpoints derived via field interviews from professionals who were competent to judge, there can be added the data relevant to this question contained in the questionnaires to medical practitioners (Study 3) and psychiatrists (Study 2). Table 7.1 provides evaluations of the adequacy of psychiatric nursing resources by doctors, and Table 7.2 provides evaluations of the training of nurses in psychiatry by psychiatrists. It should not be thought that there is any unique relationship between the two tables, since a major factor other than training is involved in the estimation of adequacy of service — the shortage of nurses trained to work in psychiatric units.

TABLE 7.1
Evaluation of Psychiatric Nursing Resources by Physicians

Type of physician	Evaluation (per cent)							
	Excel.	Good	Adeq.	Inadeq.	Very inadeq.	Non-exist.	Not known	No answer
All types	25	110	112	128	43	94	103	44

SOURCE: C. Hanly, *Mental Health Survey: Physicians* (Study 3), 1967. Based on a questionnaire survey of Ontario physicians.

It must be appreciated that the questionnaires requested information concerning the adequacy of psychiatric nursing resources in the area of the doctor's practice; that is, he was asked to make a judgement about the resources available to his patients should they require them, rather than to make an evaluation relative to the general situation in the province. Of the physicians who had an opinion, less than one-half (247) found psychiatric nursing resources in their area to be excellent, good or adequate, while 265 found these resources to be inadequate, very inadequate or non-existent.

Table 7.2 summarizes the evaluation of training in psychiatry for nurses in Ontario. Almost as many psychiatrists rated the training poor as rated it excellent or good.

TABLE 7.2
Evaluation of Training in Psychiatry for Nurses by Psychiatrists

Type of physician	Evaluation (per cent)				
	Excellent	Good	Fair	Poor	No reply
Psychiatrists	4	36	48	37	24

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967.
 Based on a questionnaire survey of Ontario psychiatrists.

Proposals for Reform

There is widespread acceptance of the need for further training in psychiatric nursing for registered nurses other than through in-service education. At present, the major places for further training are McGill University and the Allan Memorial Hospital in Montreal, although very few nurses from Ontario seem to have taken this course. The Registered Nurses' Association of Ontario endorses the proposition that further courses be established. The acknowledged implication is the recognition of specialties within nursing, both in terms of training and teaching and in terms of certification.

Two practical steps have been taken in this direction. The University of Toronto School of Nursing and the Clarke Institute of Psychiatry have agreed to establish courses to prepare teachers of nursing who will be responsible for teaching psychiatric nursing in diploma schools of nursing. The Registered Nurses' Association of Ontario has spelled out the content of the concept of a certified specialty in nursing.

Role of Registered Nurse with Certification

In clinical areas of certification:

- provides nursing in depth;
- functions as a general staff nurse in those areas where additional preparation is required for every staff member;
- functions as a team leader in areas where certification is not required and/or necessary for all general staff nurses.

In functional areas of certification:

- assumes management of a ward unit in certain situations;
- acts as a demonstrator in schools of nursing.

Nature of Courses Leading to Certification

Emphasis throughout the course would be directed to increasing the competency of the nurse in the area of specialization. The course was seen as having four main elements, the proportion of which would vary from course to course. These elements would be in the area of the humanities, the appropriate social sciences, the physical and biological sciences and clinical specialty.

The course would be given in a variety of ways to meet the needs of the persons in the local community — full-time day study and by extension.

Where Course Would be Offered

It is recommended that only those courses meeting minimum standards established by the Registered Nurses' Association of Ontario and located in an educational institution be recognized.

Such courses might be established in Colleges of Applied Arts and Technology and Diploma Schools of Nursing that have their own boards.⁶

The proposal to establish courses of this order within the province to improve the quality of psychiatric nursing would meet with no noticeable opposition from any quarter, either from nurses or from psychiatrists. There does seem to be some disagreement, however, about where these courses should be established. In addition to the above suggestion, the other locations are teaching hospitals and universities. The most satisfactory length for the course is generally felt to be six months, combining both practical clinical experience and theoretical study in psychology, psychiatry, group and individual therapy methods, the social sciences, and also the humanities.

In view of the amount of material that is to be covered, the proposal that the course be taught from September to May in a university, with the period from the end of examinations in May to September spent acquiring clinical experience under supervision, found some support. The main opposition to the longer course was based on the feeling that a calendar year was too long for many nurses. A number of nurses interviewed held that most married women have too many responsibilities to be able to afford the time. Single women who were self-supporting would probably not be able to afford the lengthy period with only bursary money, or no money at all, to support them. Also, the lengthier course might have to be taught in a university setting. This would present an obstacle for nurses remote from university centres, unless it were taught in community colleges, or partly by correspondence or extension courses.

Despite some differences of opinion concerning details, in principle these two reforms — the preparation of psychiatric nursing instructors, and the development of good quality specialty training programs in psychiatry for nurses, leading to certification in the specialty — appear to go some way towards meeting criticisms of current education. The strengthening of the psychiatric content of the three-year general nursing course also would be necessary. But the adequacy of these reforms have been questioned by a organized group of nurses — the Psychiatric Nurses' Association of Ontario.

Position of the Psychiatric Nurses' Association of Ontario

The basic question at issue is whether these steps, if carried out, are sufficient to provide the province with the number of well-trained psychiatric nurses required. This question is now being raised by the Psychiatric Nurses' Association

⁶RNAO Ad Hoc Committee to the Committee on the Healing Arts, "A Brief in Support of a Plan of Action for RNAO", 1967, pp. 8-9.

of Ontario, which claims that it is not. The Association takes the position that a special profession of psychiatric nursing, rather than a nursing specialty, is required to meet the exigencies of the situation. Thus they are advocating for Ontario a pattern of development that has already taken place in Great Britain and the four western provinces of Canada, but not in the other six provinces or in the United States.

The World Health Organization has made a recent study of psychiatric nursing. Contrary to what is stated by the Psychiatric Nurses' Association of Ontario,⁷ the WHO study does not take sides on the issue as to whether psychiatric nursing should be a distinct profession or a nursing specialty. It sets out principles for the training and utilization of psychiatric nursing which it deems to be applicable to both situations in which psychiatric nursing has developed as a specialty within nursing, and situations in which psychiatric nursing has developed parallel to general nursing as a separate profession.⁸

The alternative recommended by the PNAO would require: 1) separate training centres for psychiatric nurses; 2) separate qualifying examinations; 3) a separate registration of psychiatric nurses maintained by the Ontario College of Nurses, but distinct from its registry of general nurses.

British Columbia's Education Program

In various countries there already exist separate schools of psychiatric nursing. A good example of such a school in Canada is the one at Essondale, British Columbia. Their syllabus contains an extensive quotation from the WHO Expert Committee report already cited, which is worth repeating here. This statement outlines the major components of the psychiatric nurse's work:

The first aspect — the technical — is that of establishing procedures which will help give the patients a feeling of security and make them at least comfortable. These routines include serving meals, administration of medications, arranging for bedding, bathing, feeding and caring for clothes.

The second aspect — the social — includes over-all planning and participation in a wide variety of activities for patients at all stages of illness and recovery, giving them opportunity for work and for recreation and leisure (sic).

The third aspect of her functioning — the inter-person (sic) — becomes of central importance; in fact it is the essential part of her task. Inter-personal relationships occur during all phases of the patient's life in the hospital, from the usual events such as eating and sleeping, to the most complete such as participation in the planning of his own living . . . (The nurse) studies behaviour, attempting to understand what the patient is trying to

⁷Psychiatric Nurses' Association of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 2.

⁸Expert Committee on Psychiatric Nursing, *First Report*, World Health Organization Technical Report Series, No. 105, New York, July 1956.

communicate, and what kinds of experience he needs with people. Currently, the nurse observes her own behaviour, studying various responses and using these constructively.⁹

The stated aim of the three-year course is to "1) provide the same standard of nursing care to the mentally ill as that provided to the physically ill by other nursing professions; 2) care for the whole person while providing care 'par excellence' to the mentally ill person's *predominant* need."¹⁰ In other words, within the three years of nursing training, the psychiatrically trained nurse will receive proportionately more training in the nursing of mentally ill patients, and less in the nursing of those who are physically ill. It is in this realm that the area of controversy lies.

Registration of Psychiatric Nurses

The College of Nurses will register only those who can pass the examinations in the four major clinical fields of surgery, obstetrics, paediatrics and medicine. Most graduates of a course of psychiatric nursing could pass only the examination in general nursing and could not qualify for registration without further training. The PNAO is not willing, at the present time, to accept the establishment of a special category of registration within the general category of registered nurse and proposes a separate registry for psychiatric nurses. But the RNAO has taken a stand against the creation of another category of registered nurse (registered psychiatric nurse). Thus there exists a basic conflict concerning the future development of psychiatric nursing in Ontario between the RNAO and the PNAO.

Current Status of Psychiatric Nurses

At the present time psychiatric nurses do not enjoy a status in Ontario comparable to their peers in the jurisdictions from which they came and to registered Ontario nurses. On the whole, psychiatric nurses have lower standards of education, though not necessarily of training, and are employed only as graduate nurses, or Nurse Group I in the provincial pay scale. They cannot rise above this category until they become registered; nor can they assume supervisory positions. This situation permits and encourages the obvious anomaly of a much better trained psychiatric nurse from British Columbia working under the supervision of a general nurse who has received relatively little training for the specific nursing tasks of a psychiatric unit.

There is some agitation among both psychiatrists and directors of nurses to give more recognition to this group, but there is also opposition to them. The opposition comes, in part, from those nurses and doctors who adopt a medical model of mental illness and who feel that the medical training of the registered nurse is essential to her proper functioning. Doctors appear to feel more at ease

⁹*Syllabus for Schools of Psychiatric Nursing in British Columbia*, pp. i-ii.

¹⁰*Ibid.*, p. iii.

working with traditionally trained nurses with whose background they are familiar, and whose professional image and role they accept. But in some cases, especially when the doctor has come from one of the western provinces or from Great Britain, he is more willing to accept the psychiatric nurses with whose competence he is familiar. In fact, a few psychiatrists with this background stated in field interviews that the psychiatrically trained nurse is far better qualified than the generally trained registered nurse to work with mentally ill patients. Most psychiatrists did express the view that in their experience they have met exceptionally qualified psychiatric nurses.

On balance there does seem to be a role for the non-medically trained psychiatric nurse on psychiatric wards, even within the general hospital setting. The majority of the work done in Ontario Hospitals and in the psychiatric wards of general hospitals is of a non-medical nature, and the medical work could easily be done by having a complement of registered nurses within the ward or hospital. At the same time, if milieu therapy is to be done well by nurses, much more psychiatric training and experience is needed than is now available in the program leading to registration as a general nurse.

Proposals of the RNAO

The solution recommended by the RNAO¹¹ may be summarized as follows:

- 1) General nursing education and training should be retained with the addition of training in nursing specialties of which psychiatry would be one. Specialization would come after, rather than before, registration.
- 2) The nurse qualified in this specialty would receive a certificate above and beyond registration.
- 3) A nurse certified in psychiatry would be specifically trained to perform routine and supervisory tasks in a variety of mental health settings, but would also be trained to do general nursing.

This kind of solution appears to have certain difficulties and limitations:

- 1) There is a factor of inertia in any profession, and it is not clear how far the traditional nursing schools would or could go in updating the psychiatric content of their general curriculum for the psychiatric nursing specialty. Some nurses and psychiatrists feel that the examination of all nurses for registration should include a separate psychiatry section comparable in importance to surgery or obstetrics, and that the training of nurses should be adjusted accordingly to prepare them for it.
- 2) It is not clear how many nurses would be prepared to take the

¹¹"A Brief in Support of a Plan of Action for RNAO", to the Committee on the Healing Arts, 1967, p. 4.

special certificate training in psychiatry. Yet in the absence of a major revision of the registration courses in the direction indicated in 1), every nurse employed in a psychiatric setting should have received the certificate training, if the quality of psychiatric nursing is to be substantially improved. And it is generally agreed that it should be improved.

- 3) It follows from 2) that, other things being equal, a training program that requires an additional year is unlikely to have the desired effect on the recruitment problem.
- 4) This solution would leave the psychiatric nurses from Britain, Jamaica and the western provinces who are already here, and others who are likely to come, in a professional limbo. It would preserve the unity of the traditional nursing profession by isolating the new group.
- 5) It follows from 4) that Ontario's ability to attract these professionals from abroad will diminish.

The last point is important. Ontario will be placed increasingly in competition for these immigrants from other jurisdictions. New York, for example, has just completed a study of the state's chronic and severe nursing shortage. Part of the attempted solution will be improved salaries and working conditions; part will be a concerted effort to attract nurses from abroad.

Some of the advantages of the RAO recommendations are

- 1) The existing nursing schools could be expanded to accommodate the new psychiatric training thus avoiding the necessity of creating new schools.
- 2) The unity of nursing education would be preserved. In view of the importance of psychiatry to almost all types of nursing, it is most important that the psychiatric curriculum should *not* be split off and relegated to a special school conducting a separate training program. On the contrary, it should remain integral to the education of all nurses.
- 3) The mobility of nurses would be preserved. This feature cannot be overemphasized because most nurses are women who marry. Consequently, many of them feel a need for a greater range of employment opportunities than they would have if they were limited to psychiatric nursing, and they want to be able to find work in the vicinity of their home. This factor is somewhat diminished in importance as general hospitals come increasingly to have psychiatric inpatient services. Nevertheless, the great majority of nurses interviewed want to have employment mobility and want to be trained in such a way that they could work in a

variety of different hospital services. Consequently, general nursing training must be retained in order to recruit young women to the profession.

Proposals of the PNAO

In essence the PNAO makes the following recommendations:

- 1) Establish a separate school (schools) for training psychiatric nurses with a curriculum, staff and plant of its own.
- 2) Establish an examining body to examine candidates for registration based on their training at an Ontario school (point 1 above) or its equivalent in another jurisdiction.
- 3) Establish a special registry of psychiatric nurses (those who have satisfied the conditions in 2) above) within the Ontario College of Nurses.
- 4) Debar from practising psychiatric nursing anyone who is not registered as a psychiatric nurse.

These proposals offer several advantages:

- 1) The chances of a rapid improvement in the training of nurses in psychiatric skills would be increased by the autonomy of separate schools of psychiatric nursing.
- 2) The quality of psychiatric nursing would, in consequence, be more rapidly improved; and hospitals could depend on a greater mastery of the nursing skills in new appointments and reduce the need (which now often goes by the board) for in-service training.

But the implementation of the PNAO proposals would have two decided disadvantages. It would have the effect of bifurcating the nursing curriculum and profession. Such a split is likely to have a retrogressive effect on the quality of nursing in general. Within medicine there is a growing recognition of the importance of psychiatry for almost all aspects of clinical medicine, although its degree of importance varies with different clinical areas. What is needed is a parallel development in nursing. But this would be impossible to achieve or, at least, difficult and unnecessarily expensive, if the psychiatric component of nursing were withdrawn and established separately. Additionally, it is generally recognized that certain elements of any nursing curriculum, psychiatric or not, must be identical. This area of overlap is not inconsiderable. The creation of separate schools of psychiatric nursing thus would involve unnecessary duplication and cost.

The division between the two schools probably would aggravate the manpower problem in psychiatric nursing. Basically, Ontario must be in a position to draw nurses from its own population and train them in the province for its own services. Recruitment of professionals from Britain perpetuates a parasitical dependency on British resources which is unworthy and unworkable in the long

run. The development of nursing in mental health will have to take place in terms of Ontario's professional traditions and attitudes. Consequently, it will remain a women's profession and it will have to be able to attract women to it who will want to combine it with marriage. Hence, the demand by our nurses for employment mobility — which means a basic training in general nursing — has to be met by changes in the current system.

Perhaps one should look for a set of principles that guide one through the disadvantages of the RNAO proposals on the one hand and those of the PNAO recommendations on the other. In this connection, it is worth looking briefly at practice in the United States and in the United Kingdom.

Registration in Britain

In Britain, the separation of psychiatric nursing from general nursing is now well established. Nurse training in psychiatry leads to registerable qualification after three years, as a registered mental nurse. The course covers basic subjects common to both psychiatric and general nursing. Because of the curriculum overlap, an R.M.N. can qualify for general nursing registration (S.R.N.) with one and one-half years of additional study, instead of an additional three years (the amount of time otherwise required for preparation for the S.R.N.). The curriculum overlap amounts to about 50 per cent of the academic content and training.

In the view of senior officials of the Ministry of Health (U.K.), the advantages of R.M.N. training derive mainly from the intensive practical experience in psychiatric wards and the emphasis on therapeutic nurse-patient relationships, both of which are taken to far greater lengths than would be possible in general nurse training. Because of this, the self-reliance of the R.M.N. is noticeably greater than that of S.R.N. in dealing with psychiatric patients, and the contribution to the doctor-nurse-social worker-occupational therapist team is more valuable.

This general evaluation was supported by psychiatrists with experience in both Ontario and the U.K. These psychiatrists were especially critical of the lack of adequate psychiatric orientation in our nurses and their rather servile dependency on and subservience to doctors, which interfered with their ability to do effective work on their own. According to these doctors, Ontario-trained nurses prefer to serve dumbly rather than independently contribute to and cooperate with the doctor's involvement in the diagnosis and treatment of the patient.

Registration in the United States

The U.S. is in the midst of major changes in nursing education. These changes lead in a direction away from developments in the U.K. and present an alternative to them. Until recently, preparation for nursing registration consisted of a three-

year training program of the traditional type, combining clinical and academic work. The psychiatric clinical content of the curriculum consisted of a three-month residency in a psychiatric unit. Additionally, there have been university courses in nursing leading to the B.Sc. degree, which also led to registration. The licence to practise is a state licence established by state law.

The U.S. is now converting to university training programs through the expansion of university schools and the elimination of independent hospital schools. By 1972 the traditional three-year R.N. training program will have been phased out. It will be replaced by the four-year B.Sc.N., which is a university degree.

A new category of nursing called clinician nurses has been created in New York's psychiatric facilities. These nurses will be equivalent in rank to a supervisor, but will have no administrative work to perform. They will be paid according to the pay scales of supervisors. The clinician nurse concept has developed out of a concern that the nurse in a psychiatric unit has become increasingly remote from her traditional task, the care of patients. The nurse has been restricted increasingly to administrative and clerical activities, which are not part of her traditional function. It is hoped that the category of clinician nurse will restore the nursing function to its traditional role. It is hoped also that this upgrading of the nursing function and her training and salary improvements will attract more, and more capable, people into the profession.

In the plan being implemented in New York's hospitals, the nurse in a psychiatric clinic or ward should have no paperwork to do, but should be free to work entirely with the patients. She will organize the work of the aides; take an active part in developing recreational and social activities on the wards; perform a trouble-shooting function on the wards by keeping disturbed patients under observation and by anticipating when a crisis may arise; conduct ward meetings of patients to facilitate the growth of patient government in the wards, and take an active role in milieu therapy.

Senior members of the profession said in interviews that with the leadership of the clinician nurse who would be a specialist in psychiatric nursing, and with the improved undergraduate nursing training which would contain a richer psychiatric content, a major improvement in the quality of nursing in psychiatry would be achieved without creating a separate profession of psychiatric nurses.

It must be admitted, however, that neither the British nor the American practice can in itself be viewed as a model for development of psychiatric nursing in Ontario. In Britain a tradition of male nurses exists. This tradition may develop in Ontario, but it cannot be expected to. In the U.S., as there is no organized body of psychiatric nurses whose training background is based on the British model, changes there have not had to take this circumstance into account. It

remains to be seen how they will solve the problem when it arises because of their proposed program of recruitment from abroad — especially in the former British colonies in the West Indies. The American approach, however, is obviously in line with the directions contained in the RNAO proposals, with one major difference — the elimination of hospital training schools.

A Plan for Ontario

Ontario's training requirements should contain these elements:

- 1) A formula is needed whereby psychiatric nurses trained in the British system can receive registration of equivalent status with Ontario registered nurses but be privileged with registration for the purpose of working in a psychiatric service only. This would remove the requirement of additional training for psychiatric nurses in order to acquire equal professional status with Ontario trained registered nurses in psychiatric services. At the same time the limitation placed on the registration would mean that psychiatric nurses would not enjoy a professional status to which they are not entitled by training in non-psychiatric service settings. However, recognized status for psychiatric nurses and general registered nurses in psychiatric services will be meaningful only if the psychiatric preparation of general registered nurses is substantially improved.
- 2) Enrichment of the current training programs for the R.N. with psychiatric content both qualitatively and quantitatively theoretical and practical, is needed. The need to improve the amount and quality of psychiatric training for nurses can be supported independently.
- 3) A specialty should be developed in psychiatric nursing, requiring one year of concurrent academic and practical training at a university level. It cannot be expected that the psychiatric content of the registered nurse's training will be improved so much or so quickly that these nurses will be able to bring to hospitalized patients all the benefits that could be brought. But the nursing function in psychiatric hospitals and wards would be greatly strengthened by the infusion of leadership qualities in a specialist in psychiatric nursing. This certification should be available to psychiatric nurses trained on the British model when they qualify in terms of educational and experiential prerequisites and when they pass whatever examinations are established for certification of a nurse as a specialist in psychiatric nursing.
- 4) The development of community college-centred undergraduate nursing courses should be supported. There would be close liaison between the college schools and teaching hospitals, so that education and training could be closely integrated and pursued con-

- comitantly. It is unlikely that a sufficient number of nurses could be trained at university level alone. Further, it is not clear that high quality nursing is conditional upon university level education and training. University-trained nurses are needed also, of course, in a wide range of educational, leadership and service roles. Community colleges can more easily establish the many necessary links between the educational centres and the hospital training settings.
- 5) If these guidelines were followed rather than the proposals of the PNAO, no separate schools of psychiatric nursing would be required, and no special licensing or regulatory body for psychiatric nursing, *per se*. The functions of the College of Nursing would have only to be appropriately modified. The PNAO presumably would retain the responsibility of promoting the professional interests in Ontario of psychiatric nurses trained on the British model.
 - 6) There should also be training pathways that are realistic and *not* punitive for the psychiatric nurse to become a registered general nurse (presumably, an additional eighteen months' training) and to acquire certification as a specialist in psychiatric nursing without necessarily first acquiring registration as a general nurse (as indicated in 3) above).
 - 7) Although there does not appear to be an adequate justification for the creation of a separate profession of psychiatric nurses, the psychiatric nurses trained on the British model should receive professional recognition equivalent to that of a registered nurse and should be eligible for equal pay, status and function (clinical service and teaching) in psychiatric units. The inclusion of psychiatric nurses in the nursing profession in this way would enlist them in the service of bringing about the improvements in the psychiatric content of nursing generally that are so badly needed.

In addition to these principles, the university schools of nursing might be encouraged to undertake two developments. There appears to be a need for a four-year undergraduate program leading to a B.Sc. in nursing, and an R.N. with two years of general nursing and two years of specialization in psychiatry and related fields in the humanities and social sciences. This course might be modeled on the apprenticeship or internship system in engineering education at the University of Waterloo — that is, hospitals could pay student nurses for their internship in an amount sufficient to cover at least a substantial part of the costs of their formal education. This program would achieve three objectives: 1) integrate theory and practice; 2) upgrade the knowledge and skills of nurses and hence of the profession; 3) attract more young women into the field. Graduates of this course would be eligible without make-up courses for enrolment in the M.Sc. program in psychiatric nursing (to be discussed in a moment). They would

be eligible also for certification as specialists in psychiatric nursing with the completion of six months' work in a psychiatric unit and with passing the required examinations.

The M.Sc. in psychiatric nursing could provide an advanced training in psychiatric nursing that would be the equivalent in educational standing and function of the category of nurse clinician being developed in the U.S. These nurses, if they showed special aptitude for work in psychotherapy, could qualify for training in psychotherapy and thus provide some of the more highly specialized skills needed in mental health. Some of them might also become eligible for psychoanalytic training, since nurses are among the professional people considered as candidates by the Canadian Institute of Psychoanalysis. The degree would also provide avenues for career advancement in clinical work, teaching and research. The existence of opportunities for career advancement is an important factor in attracting people to a profession. These developments, it is hoped, would correct the weaknesses in current training for psychiatric nurses.

Treatment Centres for Emotionally Disturbed Children

There is a particular psychiatric service to which nurses with psychiatric training could make an especially important contribution: the residential treatment of emotionally disturbed children. In fact, nurses are scarcely used at all in the therapeutic programs of residential treatment centres. The main reasons for this are probably the general shortage of nurses and the inadequate preparation of nurses for the therapeutic tasks of the centre. As has already been pointed out, most nurses trained in Ontario receive only three months of psychiatric experience. Also, in Ontario, there are no graduate courses in psychiatry for nurses similar to the one offered by McGill University.

One should not, however, draw the simple conclusion that efforts should be made to prepare a large number of nurses for this kind of service. The traditional medical role of the nurse also is essential in these services, since the child patients will need nursing care for physical illnesses and the normal range of cuts and bruises from childhood accidents. Additionally, in order to fill this service gap a new kind of worker — the child care worker — has been developed. At Thistle-town Hospital, for example, the nursing staff provides traditional nursing care on a twenty-four-hour basis, and child care workers specially trained for the task provide ongoing care, direction and companionship for the patients. This approach has the distinct advantage of not drawing upon a manpower resource (nursing) which is already in short supply.

Nevertheless, there are nurses who are specifically interested in working with emotionally disturbed children. These nurses would, in all likelihood, be inclined not to work at all if no such opportunities were available to them. Consequently, their involvement in psychiatric nursing in residential treatment centres would

not be a drain on nursing resources but would provide an increase. It is to be hoped that centres for the treatment of emotionally disturbed children that are much smaller than Thistle town Hospital will be established on a catchment area basis throughout the province. As these centres could not easily afford the differentiation of the medical nursing and psychiatric care functions that is practicable at Thistle town, nurses who combined general nursing skills with psychiatric training would be valuable in such centres. There is no reason why this combined nursing skill could not be used effectively in larger hospitals also. Moreover, as services and training programs developed, nurses with a university degree involving a major in psychiatry and with postgraduate training in psychiatry would be ideal candidates for positions as senior nurse clinicians in residential treatment settings and perhaps ultimately as psychotherapists.

Chapter 8 Subprofessional Mental Health Workers

Roles of Subprofessional Mental Health Workers

At a somewhat lower level than nurses in the vocational hierarchy there is a group of workers made up of nurse's aides, attendants, custodial officers and child care workers. The position of each of these categories within the hierarchy is defined in terms of education, training and function. These personnel are becoming increasingly important in two different ways as experimentation and improvement in mental health services proceed. Aides, clerical assistants and cleaning staff are required to liberate the nursing staff from a host of routine clerical and menial tasks, so that they can contribute more directly and fully to patient treatment and care. But, in addition, the concept of milieu therapy requires that these persons should be able to interact constructively with patients, and that they should have some rudimentary understanding of the nature of mental illness. This capacity in *all* personnel in a psychiatric inpatient unit, down to and including the person who washes the floors, is especially important when they are part of the patient's total environment. What is realistically at issue here is simply the selection of reasonably healthy (mentally) individuals without the requirements of intelligence, education and training that are necessary for nursing work.

The contribution that these untrained workers make to a humane hospital environment leads to the second function, which involves a more direct contribution to a treatment program. In some settings (Guelph Reformatory is an example) custodial officers are trained on an in-service basis to conduct group psychotherapy sessions with inmates under the supervision and with the assistance of a social worker. In-service training programs for child care workers are being conducted by John Brown Camps Inc. and by Thistletown Hospital. These programs differ in a number of respects, which will be examined in another context; but they have in common the concept of training individuals to perform a set of care, custodial and therapeutic tasks at a subprofessional level. The need for this type of ancillary psychiatric personnel is widely acknowledged.

Subprofessional Psychotherapists in Service Three, New Haven

Each occupational group is different and requires separate discussion, but the underlying and guiding concept has been incorporated in experiments in the pre-

paration of ancillary therapeutic mental health personnel in the U.S. One of the most interesting of these schemes is being developed by Dr. Max Pepper at Service Three, New Haven, Connecticut. His program indicates the potential for therapeutic work that exists in subprofessional workers.

The catchment area of Dr. Pepper's Mental Health Centre is made up of two socio-economic areas, of which the largest is New Haven's negro ghetto. In the ghetto unemployment is a serious social problem. Dr. Pepper took the view that for economic reasons his Mental Health Centre should provide employment for ghetto dwellers, and that ghetto dwellers were needed as workers in the Mental Health Centre in order to establish mutual communication and understanding.

In simultaneous pursuit of both objectives, Dr. Pepper embarked on an in-service training program for black psychotherapists. The principles of selection for applicants for this training program are interesting. Education was considered of secondary importance, although general intelligence was essential. Applicants were accepted with only a grade nine or ten education. In addition to intelligence, qualities of personal maturity, healthy motivation and perception were essential. Applicants were selected on the basis of individual interviews with professional staff and through a group interaction situation in which the applicant's abilities to relate to others could be observed. Successful applicants were given an intensive training program, which was limited to three months (because three months was the training period that state authorities would provide, not because Dr. Pepper thought that it was sufficient); after this time they were set to work doing counselling under supervision with patients in the outpatient clinic.

Through supervision, these workers receive ongoing in-service training in counselling and psychotherapy. In the opinion of Dr. Pepper, the experiment with non-professional mental health workers has been successful. Some of the applicants, after two years of work under supervision, have demonstrated an unusual ability to work therapeutically with the mentally ill. They have gained for themselves an important place in the therapeutic service of the outpatient clinic, despite the threat their presence has represented to other professional staff and especially to some of the psychiatrists.

Dr. Pepper's work in Service Three provides a clear indication of what can be done by imaginative leadership despite numerous obstacles. The two principal obstacles encountered by the black psychotherapy program have been the state bureaucracy, which could not easily adapt to the terms of the problem and its solution, and the attitudes of professional monopoly towards therapeutic services on the part of psychiatrists and psychologists.

Similar Projects in Ontario

Somewhat similar projects have been undertaken in Ontario. For example, Dr. Peter Thompson, during his term as Director of the Forensic Clinic in Toronto,

developed an in-service training program for the non-medical members of the clinic (largely social workers) in group psychotherapy. Among the useful results of this program has been the work of the late Val Hartmann in developing group therapy for prisoners in the institutions of the Department of Reform Institutions. Hartmann was himself trained in this work in the in-service training program directed by Dr. Thompson. Other examples could be cited. Unfortunately the existence and success of these in-service training programs has been contingent upon the spontaneous dedication of individuals. Once they leave, the programs collapse. What is needed, then, is an institutional structure to formalize, support and give continuity to these individual training schemes.

As the questionnaire survey of psychiatrists has amply demonstrated (Tables 4.3, 4.4), many psychiatrists are interested in teaching. Some psychiatrists might well be prepared, under the proper conditions, to share their knowledge and skills with less qualified personnel. (This attitude is integral to community psychiatry, which increasingly is winning the approval of psychiatrists.) Similarly, a number of clinical psychologists, psychiatric social workers and senior nurses might be willing to engage in this type of teaching, as long as they were adequately remunerated.

Aides and Attendants

One distinct group of these subprofessional ancillary workers is formed by the aides and attendants who have graduated from the ten-month course given at the Ontario Hospitals. At present, their certificate is recognized only within the Ontario Hospital system; should they seek to work in hospitals outside the province, or in general hospitals within the province, they are usually hired at the level of trained orderlies. The aides and attendants are highly regarded by psychiatrists and nurses, and the more experienced and talented ones do valuable work with patients. In many cases they are the only persons within the hospitals who come from the same social background as many of the patients, and who share their values and goals. The main aim of the aides and attendants, beyond custodial care and supervision, is to provide what is described as remotivation — the encouraging presence of links with normal social existence.

The College of Nurses plans to inspect the training facilities for these aides and attendants with a view to recommending that those schools which offer adequate training be accredited. The graduates of these accredited schools would be recognized as registered nursing assistants (R.N.A.'s). It is felt by directors of nurses that this move would improve staff morale; presently aides and attendants are doing the same work as R.N.A.'s, but they do not have the same status and are not employed at the same level in the general hospital psychiatric wards. In most instances, the Ontario Hospital trained aide or attendant is considerably better equipped for, and more experienced in, dealing with the mentally ill than is the graduate of the straight R.N.A. course. There is no reason for this

group to be denied any longer the recognition it deserves. If any of the schools are found lacking by the College, for want of teaching staff or classroom facilities, the government might well take steps to see that these are provided.

With regard primarily to the Ontario Hospital setting, there are a number of minor positions which could be either created or filled, to remove some of the tedious responsibility from the nurses, aides and attendants. The first is the position of ward clerk. This person, who would be required only to be literate (and presumably have grade ten or even grade eight education), would be responsible for writing minor reports and requisitions, duties now performed in most instances by a registered nurse. Second, a clothing clerk, with the same qualifications, could look after the patient's clothing, keep up-to-date lists, and issue the patients with their necessities. Finally, housekeeping departments need to be established in the hospital.

Child Care Workers

Yet another group of ancillary mental health workers is the child care workers. This group is still only at the first stage of development.

In 1965 the first child care course in the province was inaugurated, backed by the efforts of the Ontario Welfare Council's Committee on Children's Institutions. The Council wanted to establish training schools for personnel who had been working merely as "glorified baby-sitters". Workers giving hour-to-hour care to disturbed children require formal full-time training. The first course began at Thistletown. Later, a course was set up at the Provincial Institute of Trade. Community colleges, such as Fanshawe in London, have followed suit. Centres such as Sacred Heart and Lakeshore Psychiatric Hospital are offering formal courses to their workers, as well as on-the-job training.

Functions

Child care workers are the key to the hourly care and companionship provided by residential institutions to their patients. They are the personnel who provide milieu therapy. A sound course in child care work is needed to prepare workers to make informed observations of the patient's total needs in relation to his disturbances, and to respond humanely and therapeutically to them. An untrained worker could cause harm to a disturbed child. For instance, in caring for a schizophrenic child, an untrained worker might unwittingly cooperate with depersonalized autistic withdrawal in the interest of promoting what he might naively consider "good" manageable behaviour. The training, therefore, must teach the worker to perceive the symptoms of a mental illness; to relate himself therapeutically to the disturbed child; to encourage the growth of a healthy, sturdy personality through daily and hourly interaction. Professional staff are responsible for diagnosis; but the child care worker, under the appropriate direction, becomes involved in an important way in the patient's treatment.

Although the child care worker cannot diagnose and is limited in his therapeutic interaction to transactions at the conscious level, he can contribute his observations and experience of a child in his care to the understanding of the professional personnel who are responsible for diagnosis and for any intensive psychotherapy or other specific treatment that might be given.

Training

The course at the Provincial Institute of Trade is perhaps typical of the training provided for child care workers. It enrolls a maximum of fifteen students who have completed grade twelve, plus five students who have had some experience in caring for disturbed children. During the first year, the student spends two days each week doing field work; in his last year he spends three days per week. Supervised work experience is provided at Boys Village, Sacred Heart, Thistle-town, Warrendale, Sick Children's Hospital, Children's Aid Receiving Centre on Huntley Street, Hagersville Reform School, Earls court, and the Lawson Residence.

The training program for child care workers at Thistle town Hospital was one of the first. It has had to provide the personnel needed to staff similar care and training services elsewhere. The educational prerequisite for admission to the course is a grade twelve education. The course covers a two-year period, and its curriculum falls into two parts: formal lectures and seminars, and supervised in-service training. One day in each work week of five days is devoted entirely to lectures, seminars and formal study. The remaining four days are devoted to eight hours of work in a clinical service under the supervision of a seasoned child care worker who is himself responsible to the psychiatric staff. The ratio of supervising staff to trainees considered desirable (by Dr. Atcheson, the Director of the Thistle town Hospital) is four trained personnel to every trainee. However, at present a ratio of only one trained child care worker to every four trainees is possible. The problems arising from this situation have been discussed in an earlier section of this report.

Limits of Competence

It is essential to the work skills and function of the child care worker, and therefore to his training, that a precise limit to his competence be drawn. Perhaps the simplest way to delineate this limit is as follows: a child care worker is trained to provide informed, understanding *care for* and *observation of* emotionally disturbed children that will effectively *support* the diagnostic and therapeutic work of psychiatrists, psychologists and social workers. The function of the child care worker is not to provide diagnosis or therapy. In keeping with this principle Dr. Atcheson, along with a majority of other psychiatrists interviewed, takes the conservative view of milieu therapy: it is to be regarded as a care program supportive to therapy. It is of very great importance, since the therapy provided by psychiatrists can be frustrated if the care environment of a residential centre is inadequate; but, despite its name, it is not in itself a therapy. Rather, milieu therapy is

a care and/or rehabilitation program. (It must be noted, however, that some psychiatrists do in fact consider milieu therapy to be a genuine form of psychological treatment.)

A Private Training Program

A rather different type of training program for child care workers is provided by Brown Camps Inc. Under this program training is provided to newly recruited staff who come into service for the most part with little or no preparation. An educational prerequisite would be a grade twelve education, but in fact most of the recruits have at least some university education and some have university degrees. The course consists of a two-year program which falls into three parts: 1) a formal component, consisting of lectures and seminars given by professional staff, including psychologists and social workers; 2) a service component, consisting of work under the supervision of a more experienced child care worker; 3) a therapeutic component, consisting of participation in group psychotherapy.

The purpose of this last component is to provide a situation in which the worker can share with other workers his emotional reactions and difficulties in his work with the children. It is not clear that the term "psychotherapy" is the correct one to use here; psychiatrists who are familiar with psychotherapy and with the sessions in the Brown Camps training program have suggested that group counselling would be a more appropriate term. Counselling involves the communication and examination of emotional and relationship problems at the conscious level, whereas psychotherapy involves the communication and interpretation of symbolic material (such as dreams) whereby the unconscious determinants of emotional and relationship problems can be uncovered and resolved. Since none of the supervisors of these sessions is trained in psychotherapy, they are said to be unable to function in group psychotherapy sessions. Dr. M. A. Fischer, who is a psychiatrist trained and experienced in the use of individual and group psychotherapy, and who has been a consultant to Brown Camps Inc., reported that he has conducted group training sessions for child care workers at Warrendale prior to its take-over by the Department of Health, but that group counselling or group training would be a more correct designation of their nature. He viewed them as providing an opportunity for child care workers to discuss problems in their new work, focusing mainly on personal emotional problems. They were not designed to uncover or treat unconscious instinctual processes. Dr. Fischer had a high opinion of the worth of these sessions as a preparation of the child care worker for his work.

The group counselling sessions for child care workers at Brown Camps Inc. are provided by Individual and Group Counselling Services whose director, William Henry, was a former employee of Warrendale and subsequently of Brown Camps Inc. Among the group leaders who provide counselling sessions for new child care workers through Individual and Group Counselling Services are child

care workers who were themselves trained by Brown Camps Inc. Mr. Henry is a social worker with broad experience in child care and welfare.

The training program conducted by Brown Camps Inc. has grown out of necessity. Many children in the province are in need of residential psychiatric care and treatment; in order to provide the personnel to do this work and in the absence of other training programs which could supply the number of workers needed to man the services, since its formation in 1966 Brown Camps Inc. has continued a training program that was already under way when its professional personnel were employed at Warrendale.

The specialists in child psychiatry interviewed were concerned about the lack of adequate facilities and personnel for the care and treatment of emotionally disturbed children. Many of them were prepared to give Brown Camps Inc. full credit for the effort being made to fill this serious gap in training and service. However, they also voiced a number of criticisms of the training program itself:

- 1) It is doubtful that anyone except the psychiatrists who act as consultants to Brown Camps Inc. is competent to dispense group psychotherapy to the child care workers, yet they (the child care workers) believe that they are receiving group psychotherapy and pay for it out of their earnings.
- 2) The same person or persons should not act as employer, employment supervisor, teacher and therapist; on the contrary, these functions should be kept completely separate. They tend to run together in the training program at Brown Camps Inc.
- 3) A treatment program in conjunction with a training program for child care workers should not be a condition of employment. The unfortunate fact is that the pressures inherent in the institutional and professional inadequacies of current facilities make it difficult to see how any group — however good their intentions, and however much they might want to build into their training programs safeguards of the kind implied by these criticisms — would be able to do so.

The Need for Independent Training Centres

It is important that new institutional and professional resources should be created to fill the gaps. A viable possibility would appear to be emerging already in the community colleges. Teachers in clinical psychology, social work and nursing could be added to the faculties to provide independent formal and seminar instruction in conjunction with supervised apprenticeships in clinics, hospitals and residential centres.

It must be pointed out, however, that there is a substantial difference between *some* of the child care workers developed in the Brown Camps Inc. training program and all of the child care workers developed in programs such as Thistle-town's. Some of the child care workers at Brown Camps Inc. are university

graduates. A few of them have had brilliant undergraduate careers. Because of their ability to advance to the highest levels of education and service these individuals are capable of a greater career development than any program for training child care workers could possibly provide. In fact, their training as child care workers leaves them in a professional limbo, because they are seriously under-trained relative to their inherent intellectual and personal capabilities.

These persons shed a very clear light on a basic inadequacy in Ontario's postgraduate education in mental health. They are young people strongly motivated to service in the mental health field, without any interest in medicine but with excellent undergraduate degrees, who have no opportunity for postgraduate education that is 1) service-oriented and 2) preparatory for worthwhile, responsible and demanding diagnostic and therapeutic work in mental health services. This problem takes us beyond the limits of the present discussion and will have to be taken up in another place. Suffice it to say here that the solution to the problem appears to require the establishment of a new postgraduate training program in therapeutic psychology.

There are disadvantages inherent in a highly stratified status structure among employees in the same service. One is the possibility of tension among employees, and a high turnover of staff when persons find themselves trapped at a level that inhibits their potential growth and places them in a position of subservience to persons whom they may regard as in no way superior to themselves. On the other hand, only a very poor quality of worker may be attracted to these low level occupations. To avoid these disadvantages, an employment structure is desirable in which upward mobility is possible for those who are capable and interested in advancement through further training.

Such a structure might consist of these elements:

- 1) A category of mental health worker could be established with a system of gradients from the menial and clerical workers described above, through aides, custodial officers, attendants, child care workers, psychiatric nurses (British model) to subprofessional mental health counsellors.
- 2) A series of courses could be formed, graduated in terms of their difficulty and content and taught at community colleges, to which mental health workers could go for the additional instruction needed for advancement.
- 3) A sabbatical leave system could be established, whereby a mental health worker who had the necessary qualifications could continue his employment and receive further education and more senior staff members could be used as the apprenticeship component of the more advanced training, and could run concurrently with the additional formal lecture and seminar work at the community college.

- 4) An accrediting, examining and registering board could be established to accredit courses in community colleges and hospital apprenticeships, to establish general examination standards for the more advanced grades of mental health worker, and to establish registration for these personnel, with procedures for removing unsuitable persons from the register. The board should be composed of senior mental health workers, senior members of the other mental health professions, independent educators, and representatives of the public interest.

This system would have a number of additional advantages besides the ones already cited above.

- 1) It would introduce a degree of cohesiveness and stability into developments which now tend to be rather chaotic and sporadic, and militate against an unnecessary proliferation of distinct sub-professional groups working in the field with highly diverse and often unknown qualifications.
- 2) It would provide a mechanism for public support for the further training of these workers. It would involve the community colleges, thus multiplying the utilization of the faculty resources they will have to develop if they become involved in the training of nurses.
- 3) It would provide an additional type of registration and perhaps the more appropriate one for psychiatric nurses trained on the British model. Persons with these qualifications could be admitted to the penultimate grade of mental health worker. This registration, because it is uniquely in the mental health field, would be more suitable than a nursing registration. Such a registration also would be congruent with public attitudes concerning the identification of nursing as a woman's profession. In fairness to the training that psychiatric nurses have, however, it would be necessary to establish professional parity between registered nurses and this grade of mental health worker. It would be necessary also to enable this classification of mental health worker, who has the educational prerequisites, to proceed to the M.Sc. in psychiatric nursing, so as to qualify for the most advanced teaching, clinical and supervisory tasks and positions within the competence of the nursing profession.
- 4) The carefully planned development of mental health workers of all types would be a major influence in the expansion and improvement of various types of mental health facility: psychiatric units in general hospitals, community mental health clinics, residential treatment centres for emotionally disturbed children, rehabilitation centres, and the reform institutions of the province, not to mention the treatment and care programs of mental hospitals.

Chapter 9 Psychiatric Social Workers

Definition of the Term

There are four different conceptions of the nature and training of a psychiatric social worker.

- 1) A psychiatric social worker is a general social worker employed in a mental health service. His functions usually include the following: taking social histories of patients; establishing effective liaison with families of patients or social agencies that will be needed by the patient during his hospitalization; assisting patients with post-hospitalization; rehabilitation; communicating with other mental health professions — such as psychiatrists, psychologists and nurses who are more directly involved in the diagnosis, treatment and hospital care of the patient — concerning his social history and situation; and contributing generally to milieu therapy. In order to do this work a social worker requires a general training with sufficient knowledge of mental illness to perceive and understand the health problems of the patient. But his major skills and their focus concern the patient's social situation.
- 2) A psychiatric social worker is a general social worker employed in a mental health service to do the work described in 1), and also equipped, through supplementary in-service training in psychodiagnosis and psychotherapy, to treat certain patients individually or in groups (especially family groups) by means of counselling and psychotherapy. It is desirable but not necessary for the psychiatric social worker to have received extensive formal and practical training in psychodynamic psychology and psychopathology as part of his social work education. In any case, in order to perform this additional function supplementary in-service training is necessary, usually under the direction of psychiatrists, and after formal training has been completed.
- 3) A psychiatric social worker is a social worker who has received specialized M.S.W. training in the diagnosis and treatment of emotionally disturbed persons by means of counselling and psychotherapy. Such a social worker would be equipped to share fully in the psychological aspects of the work of psychiatry (just as a clinical psychologist might) in a mental hospital, mental health clinic, or forensic service. He would not, however, be thoroughly

trained in general social work and would not be as well equipped to perform the services enumerated under 1) as a social worker who was so trained.

- 4) In order to do justice to the realities of social work practice in Ontario, it is necessary to add a fourth concept. A social worker is a former nurse, teacher, or custodial officer in a training school, or a similar person, who has been employed to do the work of a trained social worker and who may receive some in-service training by an M.S.W. in psychiatric social work as described in 1). No doubt there are numerous skilled social workers generated for service in Ontario's institutions and agencies in this way, but the principal reason for the employment of people so trained is the chronic shortage of trained social workers.

A variant on this type of social worker is the graduate of a training program in social work at Ryerson Polytechnical Institute or at certain community colleges.

There are psychiatric social workers of all four types practising in Ontario, although for a reason that will be discussed in a moment, the third type is uncommon relative to the others. Suffice it to say that the designation "psychiatric social worker" is so intrinsically ambiguous that no simple and unequivocal definition can be given. Each of the first three conceptions answers to a need for a specific kind of service, or combination of services, at a professional level. As might be expected, there has been some disagreement among social workers themselves concerning the nature of psychiatric social work, the training preparation necessary for it, and its place in social work generally. In order to understand the current situation it is necessary to grasp some details of the history of social work in Canada and the United States.

Historical Developments

Historically, social work in Canada and the United States has been divided into a variety of separate segments. There have been associations for psychiatric social workers, for medical social workers, for school and probation social workers. This separation into specialties has been characteristic of training programs also.

In 1955 the National Association of Social Workers in the United States was established to bring about the unification of these disparate, separated, sometimes conflicting, types of social worker. The aim since then has been to encourage a general common base of competence and of function on the part of social workers, whatever their specific field of vocational activity may be after their training and internship has been completed. The rationale behind this concept is that every social worker has to cope with a specific group of interrelated problems focused upon social relationships of all kinds (employment, familial, recreational, legal, and so on). The psychiatric social worker, for example, needs to be familiar with the

functioning and nature of the school system, of probation and court systems, and of various agencies and institutions in the society. Consequently, the Council of Social Work Education has adopted the policy that there should be no specialization of accreditation and no specialization of curriculum in terms of subdisciplines, such as psychiatric social work. Instead, there has been established throughout the United States and Canada a generally accepted basic curriculum for the training of social workers.

Within the National Association there are divisions called councils. There is a Council of Mental Health and Psychiatry, a Council for Social Workers in the Schools, and a Council for Probation Officers. Thus, the social worker who does specialize (and most social workers specialize to some extent) will have recourse to a subdivision of the total organization which is specifically interested in his particular area of practice.¹

The essential meaning of this development is that through their official national organizations and training programs, social workers have themselves opted for the concepts of psychiatric social workers embodied in definitions 1) and 2). This policy accounts for the small number of psychiatric social workers in the third sense.

Accreditation of Social Work Training

The organizational structure for the accreditation of schools of social work is of special interest, because it provides a model that may be applicable to clinical psychology. It has the interesting feature of providing for a fairly uniform North American standard.

The Council of Social Work Education is an international body. It has affiliates throughout the United States and Canada, and it serves both countries. Its principal function is to establish and maintain standards of education and social work practice through the accreditation of schools for the training of social workers in North American universities. The accreditation involved is voluntary rather than legal. That is to say, accreditation is based on the force of peer judgement, rather than on the force of law supported by fixed penalties. The sanction of peer judgement has been found to be adequate to establish the kind of control over standards, curriculum and training that the Council feels is in the best interest of the profession.

Social Work Training

It has been the task of the Council of Social Work Education to develop a basically uniform curriculum for the training of social workers in the schools of the United States and Canada on the basis of the general principles already discussed.

¹Field interview with the Associate Director of the Council of Social Work Education.

Two important parts of every training program are methodology and field work experience, through which the student masters the practical skills of his profession. Some variation occurs in the way in which field work is introduced into the program at any given school. Either the concurrent plan or the block plan may be used. The concurrent plan consists of the integration of field work with ongoing formal lecturing and seminar work; the block plan separates off the field work as a special segment of the academic year, during which the social worker in training devotes all his time to field work.

The Curriculum

Four elements make up the nucleus of the curriculum of any school of social work: the study of individual human growth and the social environment; social policy and services; methodology; and field work. Methodology includes three specific topics: casework, group work, and community organization.

The individual student may concentrate on one or other of these methods. However, new thinking in social work is seeking to combine the methods, so that students will be competent to handle each. Also, administration and research are being stressed increasingly, although they are not now major elements in the methods program.

The choice of method is important as far as the nature of the future involvement of psychiatric social workers in mental health services is concerned. Psychodynamically oriented psychiatrists have stated in field interviews that a social worker with the necessary personal qualities, who has received a thorough training under supervision in casework as part of the M.S.W. training, is an excellent candidate for in-service training as a mental health counsellor or psychotherapist. Indeed, many of them are of the opinion that social workers have better background preparation for work as psychological therapists than have clinical psychologists, because of their casework training.

On the other hand, the social worker whose methods training and field work experience have been concentrated on group work and community organization may be a more valuable associate of the community psychiatrist. In fact, a case could be made for the view that community psychiatry is essentially a specialty within social work, and could be done most economically and effectively by social workers with a training beyond the M.S.W. in psychiatry.

At the present time, in addition to the Master of Social Work training programs, in the United States and Canada there are fifteen universities offering doctoral programs.

Status of Psychiatric Social Work

There has been and there remains some conflict within the social work profession concerning the status of psychiatric social work. Psychiatric social workers of the second and third type have tended to view themselves as apart from and superior

to general social workers. The official policy of the Council of Social Work Education is based on the concept that all social workers are on an equal footing, and that a specialty is something that derives from basic general practice. There are many social workers in the United States and Canada, however, who see themselves essentially as individual therapists. Their preferred work setting is in clinical practice in association with other mental health professionals. The Associate Director of the Council takes the view that the impact of community psychiatry will tend to encourage social workers with an interest in mental health to work more in the community with agencies and groups, and to be less interested in individual and group psychotherapy and counselling.²

Relationship of Psychiatric Social Work to Psychiatry

Although a psychiatrist has wider and more comprehensive training in physical as well as mental health problems than a clinical psychologist, he does not necessarily have more advanced training in certain aspects of human psychology; and he will certainly be less well trained in research than many Ph.D. psychologists. The social worker has a training that is neither as comprehensive nor as advanced as that of the psychiatrist. He has, however, a specific area of expertise which makes it possible to make an independent, if ancillary, contribution to the diagnosis, treatment and care of the mentally ill.

The questionnaire to psychiatrists (Study 2) shows an active use of social work services by psychiatrists in clinical settings for diagnosis, treatment and general care (see Table 9.1). But forty-one psychiatrists who devoted at least part

TABLE 9.1

Utilization of Psychiatric Social Workers for Diagnostic Tasks by Psychiatrists

Number of psychiatrists	Percentage of cases of psychiatrists to which psychiatric social workers make a diagnostic contribution				
	0-20	21-40	41-60	61-80	81-100
	31	15	8	10	10

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

of their time to clinical practice did not utilize social workers for diagnostic work. As will be indicated below, part of the reason for this is not a lack of desire on the part of psychiatrists to seek the assistance of a social worker, but the fact that no social workers are available. But another factor is that clinical psychologists usually have more diagnostic skills than social workers. The casework background and orientation of social workers inclines them towards greater involvement in therapy.

²*Ibid.*

TABLE 9.2**Utilization of Psychiatric Social Workers for Therapy by Psychiatrists**

Number of psychiatrists	Percentage of cases of psychiatrists to which psychiatric social workers make a therapeutic contribution				
	0-20	21-40	41-60	61-80	81-100
	37	19	16	8	7

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

As Table 9.2 shows, more psychiatrists utilized psychiatric social workers for therapeutic procedures. Twenty-eight of the 114 psychiatrists in the sample who devoted at least part of their time to clinical practice did not utilize social workers for therapeutic work. This number is substantially less than the number of psychiatrists (forty-one of 155) who did not utilize social workers for diagnostic purposes.

Fewer social workers were used for general care in clinical services — no doubt because this would be a rather extravagant use of a scarce professional resource, and one that could be performed by nurses or by subprofessional personnel. Given the ambiguity in the designation "social workers", it is likely that few if any of the social workers referred to in Table 9.3 are M.S.W.'s.

TABLE 9.3**Utilization of Psychiatric Social Workers for General Care of Patients by Psychiatrists**

Number of psychiatrists	Percentage of cases of psychiatrists in which psychiatric social workers contribute to their general care				
	0-20	21-40	41-60	61-80	81-100
	20	15	5	1	4

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

Seventy psychiatrists in the sample of 115 who devoted some part of their work week to clinical services did not use social workers for general care.

The shortage of these professionals is indicated by the fact that eighty-eight of the 115 psychiatrists said that they would utilize more social workers if more were available, while only seventeen were satisfied with the current supply. Ten did not reply to the question.

In response to the question, "Should the psychiatric social worker work with patients only on referral from a doctor?" sixty-nine psychiatrists in the sample answered affirmatively, forty-one answered negatively, and five gave no response.

The above data relate to the interrelation between psychiatry and social work as seen from the experience of psychiatrists with a predominantly hospital and

clinical practice. As one would expect, comparable data for the group of psychiatrists whose practice is predominantly private show much less utilization of psychiatric social work.

Only twenty-nine of these psychiatrists used the assistance of psychiatric social workers in the diagnosis of their patients, and only for a few patients at that. Also only twenty-nine of these psychiatrists used psychiatric social workers in the treatment of some of their patients; eleven psychiatrists used them for general care. This situation is explained largely by the fact that private practice in psychiatry consists mainly of the treatment of psychoneurotic disturbances by means of psychotherapy on an individual basis. The contributions that most social workers could make are not particularly relevant. Furthermore, the typical employment patterns in social work are not compatible with the establishment of cooperative work relations with psychiatrists in private practice. It is noteworthy, however, that of the 103 psychiatrists in this sample, seventy-seven stated that they would use the service of psychiatric social workers more frequently if more were available; only nineteen stated that they would not; and seven made no reply to the question.

This group of psychiatrists more strongly held the view that referral from a doctor is necessary. Sixty-nine expressed this opinion, twenty-nine thought referral from a doctor unnecessary, and five gave no opinion.

Psychiatrists of both subgroups (that is, all psychiatrists who responded to the questionnaire) mentioned the following criteria for the utilization of social workers to perform mental health services. They are scaled in order of frequency. The figures on the right give the frequency with which a criterion was cited.

1) Family counselling (family as patient unit)	78
2) Social casework (case histories, supportive counselling of patients and liaison with families of hospitalized patients)	64
3) Presence of social problems that require mobilization of community resources	53
4) Group and short-term psychotherapy — therapy similar to that done by psychiatrists if the social worker is trained to do therapy	46
5) Counselling in the absence of psychiatric pathology and/or organic illness	13

Evaluation of Training

Psychiatrists were not enthusiastic about the training received by social workers for the purpose of service in mental health facilities, although they rated social workers' training somewhat more favourably than the training of clinical psychologists.

TABLE 9.4
Rating of Training of Psychiatric Social Workers by Psychiatrists

Excellent	5
Good	44
Fair	56
Poor	20
Unknown	18
No response	6
	149
Total	149

SOURCE: C. Hanly and W. Christian, *Mental Health Survey: Psychiatrists (Study 2)*, 1967. Based on a questionnaire survey of Ontario psychiatrists.

Evaluation of Services

The assessment of social work services in mental health facilities in the practice areas of the general practitioners and specialists surveyed is not very enthusiastic.

TABLE 9.5
Assessment of Social Work Services in Local Mental Health Facilities by Physicians

Excellent	29
Good	91
Adequate	161
Inadequate	146
Very inadequate	60
Non-existent	71
Unknown	26
No response	75
	659
Total	659

SOURCE: C. Hanly, *Mental Health Survey: Physicians (Study 3)*, 1967. Based on a questionnaire survey of Ontario physicians.

The ratings of inadequate or worse (277) almost equal the ratings of adequate or better (281). These ratings are to be explained almost entirely, either directly or indirectly, by the shortage of M.S.W.'s in the province: directly, for the obvious reason; indirectly, because vacancies for positions that require an M.S.W. have been filled by inadequately trained personnel.

Extent of Shortage of Psychiatric Social Workers

The extent of the shortage of social workers in community psychiatric services and Department of Health psychiatric services has been determined recently by Raymond Berry, Advisor in Psychology, Professional Services Branch, Mental

Health Division, Department of Health. Berry's findings showed that there are 201 social workers in these services: ninety-nine are in community psychiatric services, 192 are in Department of Health services; nineteen are part time and 182 are full time; 130 spend part of their time in inpatient services, 107 in outpatient services; 145 are in adult services and eighty-nine in child services. The sum of these figures is greater than the number of social workers because many of them, taken individually, work in more than one service within a hospital or clinic.

There are fifty-one vacancies for social workers in community psychiatric facilities. There are forty-four vacancies for social workers in Department of Health facilities. The total shortage of social workers for existing positions (which should not be confused with needed posts in needed services) is ninety-five. To this may be added the vacancies for psychiatric social workers in the Department of Reform Institutions, in private residential treatment centres for emotionally disturbed children, and in social agencies — all of which require social workers who are skilled in dealing with mental health problems. There is also a need for more mental health counsellors and psychotherapists; and, although, social workers are not usually trained specifically to perform these tasks, their case-work experience provides those of them with a special aptitude for dealing with mental health problems with a background for training in psychotherapy. In fact in numerous hospitals and clinics social workers undertake individual and group psychotherapy.

Function of Social Workers in a Large Mental Hospital

The effective range of social work practice in a hospital setting is well illustrated, for our purposes, by the work of the twenty-one qualified social workers at New York's Bellevue Hospital.

The social workers are members of psychiatric teams. They provide a social history of the patient to the psychiatric team as part of the data for the creation of a therapeutic program. They contribute to the social life of hospitalized patients by helping patients to orient themselves to hospital routines and procedures; by organizing patient board meetings, at which patients express their views concerning the hospital and suggest changes; and by organizing social and recreational activities. They contribute generally to milieu therapy. They receive formal referrals to discuss some aspect of his hospitalization with an individual patient, to discuss a patient's welfare with a concerned social agency, to discuss a patient's welfare with his family. The social worker generally maintains links between the patient and his family, and between the patient and his community. A small number of social workers, approximately three to five of twenty-one, dispense group psychotherapy in the mental hygiene clinic.³

³Field interview with the Director of Psychiatric Social Work Service Department, Bellevue Hospital Psychiatric Unit, New York.

The salient features of these functions for the purposes of our discussion are as follows:

- 1) In general, psychiatric social work involves, not sharing the work of psychiatrists and clinical psychologists, but making a separate although cooperative contribution to the care and treatment of patients.
- 2) Given special aptitude and when a need exists, the social worker may be prepared by in-service training to undertake psychotherapy with patients, as illustrated by the three to five social workers in the Bellevue Psychiatric Unit who give group psychotherapy.

The principle that emerges is that psychiatric professionals (psychiatrists and psychologists) who are formally trained in psychotherapy are responsible for supplementing the formal training of social workers with the training in psychotherapy necessary to undertake this work. There appears to be no reason why a social worker, once trained, cannot practise psychotherapy, as long as he works in collaboration with a doctor and treats patients only after they have received a medical examination (for the reasons already discussed in relation to clinical psychology). These reasons are implicit in the criteria in terms of which psychiatrists make referrals to psychiatric social workers for treatment. But a general licence to practise social work should not include the right to practise psychodiagnosis and psychotherapy.

Licensing

In general, throughout the United States and Canada there has not been any licensing of social work by state or provincial legislatures. Four or five states, however, have licensing procedures. Among these are New York, California and Rhode Island. The National Association has been actively promoting state certification and licensure for social workers. As far as the National Association is concerned, the criterion that should be applied in any such legislation is that the candidate for licence must have a Master of Social Work degree from an accredited university.

The question of licensure of social workers as such is not at issue in this report; however, the question of a special licence for psychiatric social workers is. Given the policies of the National Social Work Associations of Canada and the U.S. concerning the training prerequisites for licensure, social workers cannot be licensed to perform psychodiagnosis and psychotherapy as clinical psychologists can be.

The New York law which certifies social workers in the State of New York is premised on the following description of social work practice.

A person practises social work when he engages in the practice of social casework, social group work, community organization, administration of a

social work program, social work education, social work research, or any combination of these, in accordance with social work principles and methods. The practice of social work is for the purpose of helping individuals, families, groups and communities to prevent or to resolve problems caused by social or emotional disorders.⁴

Nothing prior or subsequent to this description in the law provides a more precise definition of what exactly is involved in "helping individuals, families, groups and communities to prevent or to resolve problems caused by social or emotional disorders". But within the paragraph itself there occurs the controlling description of the nature of these services, "in accordance with social work principles and methods".

Given the philosophy behind the accreditation of social work training programs, these principles and methods cannot be deemed to include psychodiagnosis and psychotherapy. The social worker could be expected, as could any properly trained teacher, to have some ability to identify the presence of a psychiatric disorder in a client or pupil, but would be expected to refer the individual in whom such a disorder was suspected to a psychiatrist or a psychologist via a medical practitioner. Consequently, licensure of psychiatric social workers could not establish the right to perform psychodiagnosis or psychotherapy, and would presuppose the concept of psychiatric social work in definition 1) above.

The adoption of this principle would combine harmoniously the predominant view of their own professional role among social workers themselves and society's needs for services, which are premised on an understanding of emotional disorders and human conflicts but which are basically directed towards exacerbating environmental difficulties. As the next section of this report will show, there is an urgent need for preventive and rehabilitative services to support the intensive treatment of psychiatric disorders conducted in general hospital and Ontario Hospital services. It is for this kind of role in mental health that the general social worker is best suited by his training. The essential roles of the social worker in mental health according to this concept would be

- 1) The early identification of emotional disorders, their referral to appropriate diagnostic and therapeutic resources, and the provision of a social history of the individual.
- 2) The mobilization of community support resources when needed.
- 3) Counselling and supportive work on behalf of the social well-being of the individual (assistance with employment, educational, legal, and other environmental problems in which the individual may be enmeshed).
- 4) The establishment of effective liaison among the various individuals and agencies that may be involved in assisting the individual.

⁴Laws of New York, Chapter 334, Article 154 Social Work.

Supplementing Social Work Training

There are at least three ways of providing social workers with the supplementary training needed by them to become psychotherapists. One is through in-service training; another is through Ph.D. programs; and a third is through special internships, such as those offered by the Jewish Board of Guardians in New York.

An in-service training program conducted by P. G. Thomson, M.D. at the Forensic Clinic has been described already. Its benefits in terms of experimentation in group therapy at Guelph Reformatory will be described later.

At present there are, in addition to the Master of Social Work training programs in the United States and Canada, fifteen doctoral programs organized in fifteen schools for specialized studies. The Ph.D. in social work could be trained in psychodiagnosis and psychotherapy.

The Jewish Board of Guardians in New York provides advanced training in child guidance practice and community mental health consultation for M.S.W.'s with a minimum of three years' supervised case work practice experience. It provides both academic lectures and seminars on such subjects as child development, evaluation and differential psychosocial diagnosis of children, theoretical approaches to the treatment of children and their families, and supervised control cases in diagnosis and therapeutic counselling. All supervision for diagnosis, consultation and treatment is conducted by trained psychiatric social workers, child psychiatrists and clinical psychologists. Supervision is conducted both individually and in small groups of two or three for approximately four and one-half hours per week. Training in group therapy is supervised by the clinic's group therapy staff. The qualifications required for candidates in this program are high:

- 1) Graduates from an accredited School of Social Work with specialization in social casework.
- 2) Aptitude for therapeutic work with children and parents. Previous professional experience with children is not a requirement but is desirable.
- 3) A minimum of three years of supervised, postgraduate experience in an interdisciplinary clinic setting or casework agency. For the more advanced workers, some experience in casework supervision and demonstrated potential for leadership are required as major assets.
- 4) Personal psychoanalysis or psychotherapy is not a requirement by highly recommended.⁵

The Case Against Advanced Training

A question inevitably arises concerning the wisdom, as far as Ontario is concerned, of such advanced training in mental health for social workers, when general social workers are in such short supply. The point of this question may be emphasized by a brief examination of social work services in an area of rural

⁵*Advanced Training in Mental Health*, published by the Jewish Board of Guardians, New York, 1967, p. 17.

Ontario. Huron County was selected as being reasonably typical of a rural area without a major urban centre (such as Kitchener, London or Windsor) within its boundaries.

The Children's Aid Society of Huron County was founded during 1967, jointly by the provincial government and the County of Huron, on a formula according to which the province paid 40 per cent of the operating costs from January to April and 60 per cent for the balance of the year, the county covering the remainder. Its total budget was \$118,000. Actual costs were approximately \$150,000. The number of children in care in January in 1967 was sixty-two; the number in December 1967 was ninety—an increase of approximately 45 per cent.

The reasons for the children being taken into care are 1) neglect by parents; 2) uncontrolled, antisocial behaviour; 3) parental incapacity as a result of illness (psychiatric or other); 4) financial incapacity of parents; 5) death of parents. Of these the last is of negligible importance and the first is the principal cause. Parental neglect is itself caused most often by alcoholism within the family or by family breakdown.

The intake arrangements require an appearance before juvenile and family courts in order to establish custody and a medical examination of the child by a general practitioner. Placement is in a foster home in almost all cases. Placement in a training school occurs only if a legal offence has been committed. Children suffering from obvious emotional disturbances will be sent to a residential treatment centre such as Lorimer Lodge, Craigwood or CPRI (Children's Psychiatric Research Institute) in London. The county is not at all satisfied with existing care and treatment for emotionally disturbed children, because no facilities exist within the county. None exists proximate to it, except the few institutions named. County health officials currently are investigating the possibility of utilizing group homes run by specially selected foster parents.

There is an Ontario Hospital at Goderich, but it is chronically short-staffed in all departments and has yet to open an outpatient clinic for adults. There is a plan for a new outpatient clinic for emotionally disturbed children at the hospital, with Huron County as its catchment area. This plan involves the use of existing physical facilities and the employment of a specialist in child psychiatry. The plan cannot be put into effect, however, because there are no personnel available.

Children having difficulty in foster homes receive psychological assessments by a psychiatrist associated with CPRI in London, who is employed two days per month by Huron County's Children's Aid Society. This work began in October 1967 and involves, in addition to the assessment of problem children, lectures to and consultations with the social work staff in the hope that they will eventually be able to do mental health counselling and psychiatric casework.

The Society has six social workers and one social work director. Only the latter is an M.S.W. Two are former teachers, two are registered nurses, one is a registered nursing assistant, and one is a former recreational therapist at a boys' training school. The statistics for the service in 1967 show that these personnel are heavily committed to a wide variety of service beyond the care of emotionally disturbed children.

TABLE 9.6
Huron County Children's Aid Society
Statistics for 1967

Number of families served in 1967 involving 556 children	159
Taken into care	52
Returned to parents	21
Cases open December 31, 1967 involving 250 children	72
Services to Unmarried Mothers	30
Putative Fathers	21
New Agreements	3
Children of unmarried mothers in care January 1, 1967	22
Children of unmarried mothers taken into care during year	47
Children of unmarried mothers in care December 31, 1967	25
Total number of children in care January 1, 1967	62
Total number of children in care December 31, 1967	90
Applications to board children received	74
Foster homes used during year	83
Foster homes in use December 31, 1967	36
Adoption applications received	82
Withdrawn	42
Approved	43
Number of Huron C.A.S. children adopted	25
Number of other Society children adopted	13
Number of children privately adopted	7
Days of care provided	27,771
Official guardian reports	17
Number of addresses given by staff	25

SOURCE: Huron County Children's Aid Society, 1967.

The average case load for the Society's staff at any time is thirty to forty. Additionally, some have undertaken constructive initiatives in the area of prevention. B. Corbett, the former recreational officer, has organized a Family Counseling Service as a pilot project in remedial intervention with problem families. The Service is manned on a voluntary basis by a clergyman, a bank manager, a lawyer and the local Medical Officer of Health. The members of the Service offer counsel and guidance in relation to their area of experience to married couples in the county who are experiencing domestic problems. The local M.O.H. is keenly

interested in developing mental health services in the county, but has been frustrated thus far by a county council that refused to vote funds to employ a psychiatrist for the County Health Unit and by the unavailability of psychiatrists, even if money were voted.

County officials, as distinct from county politicians, see a need for more trained social workers to do more and more effective work along the lines of the Family Counselling Service. In the light of this need it would appear that priority for training expansion in social work should be given to the education of general social workers.⁶

The Case in Favour of Advanced Training

But there is also a perceived need in the county for mental health services, not only for the children who are taken annually into care by the Children's Aid Society, but also for their families, not to mention others. Because of the even worse shortage of psychiatrists and clinical psychologists, a case can be made also for the training of social workers to provide special mental health services to emotionally disturbed children and their families, working in liaison with local medical practitioners and the district M.O.H.

Two additional arguments may be adduced to support the view that social workers with the necessary interest and aptitude should have available to them opportunities for acquiring advanced specialist training in mental health. It is true of any profession that its ability to provide opportunities for greater professional challenge, advancement, responsibility and reward is an essential part of its ability to attract, hold and effectively utilize the most able people. At the present time, there are young people graduating from our universities who have the interest and motivation for a social work career, but who are concerned that it does not provide them with the opportunities for career development of which they feel themselves capable. The presence within the social work profession of members with advanced training in mental health would provide the profession with a group of educators who would have the experience and knowledge necessary to provide sound mental health content to the training programs in general social work. Also, in many different ways, they could maintain effective liaison and communication between psychiatry and psychiatric services, and social work and social work services.

Problem of Certification

If one accepts the view that there is a need for psychiatric social workers with advanced mental health training and with specialized training in the treatment of emotionally disturbed children and their families, a problem arises concerning the certification and licensing of these social work specialists. They would, of

⁶Field interview with Associate Clerk-Assistant of Huron County.

course, be licensed social workers already, since only an M.S.W. would be eligible for advanced training. As such they would be responsible for taking case histories, and this would involve basically two aspects: 1) a social diagnosis of the problems of a family, for which they would be entirely responsible; 2) contributions to the psychodiagnosis of the problem child or emotionally disturbed child, which would be the responsibility of a clinical psychologist or psychiatrist. They would be responsible as well for casework with families, consisting of not only mobilizing the community resources necessary to help the family with its problems and guiding the family to them, but also counselling the family concerning these problems. But the responsibility and privileges of a licensed M.S.W. should not normally include psychodiagnosis and psychotherapy.

The consideration of certification and licensure of social workers for these specific clinical functions would make sense if, and only if, a post-M.S.W. training program comparable in scope, quantity and format to the training of psychiatrists in psychodynamics were available to social workers.

As indicated above this could be provided in three ways: through doctoral programs, through non-university post-M.S.W. formal training, and through in-service informal training. The School of Social Work at the University of Toronto offers a doctoral program. But it does not offer a doctoral program that would prepare a social worker to perform psychotherapy. Neither are there training programs for M.S.W.'s in Ontario of the type offered by New York's Jewish Board of Guardians. It is left to informal, in-service training to provide such preparation in psychotherapy as is available to social workers. It is difficult to see how such a preparation can be formalized in terms of registration, certification or licensing. Since training is informal, an informal responsibility for the use of the training appears to rest with the psychiatrists who teach social workers to perform psychotherapy. It would appear that an outpatient clinic or similar service to which psychiatrists are attached is the most appropriate service environment for social workers involved in psychotherapeutic work with patients.

Conclusions

The nature of training in social work at any level up to and including the M.S.W. does not warrant the creation of any special type of registration, certification or licensing of psychiatric social workers. Potentially Ph.D. and other formal non-university training programs at the post-M.S.W. level might warrant it; but they do not do so at present. The informally trained social work psychotherapist is usually adequately prepared and supervised by the other mental health professionals (usually psychiatrists) in the service in which he received his in-service training. A problem arises in the case of social workers who, having left the service in which they have received their informal training, may practise psychodiagnosis and psychotherapy without the necessary medical safeguards through referrals from doctors. Further, our society needs the services of social workers

with proper motivation and psychodynamic training. It is not clear that we always utilize the resources of such professionals to the full. There is also the problem of the psychiatric social worker who has received an adequate preparation in psychotherapy, and who finds himself in a professional limbo because he is not a typical social worker, or a psychiatrist, or a clinical psychologist—although he is competent to perform some of the services of psychiatrists and clinical psychologists. Hence, there arises a need for a type of registration that will correctly identify the nature and limitations of the expertise exercised by a psychiatric social worker with advanced psychodynamic training. There is a correlative need for a training program and examination for these professionals.

There are now enough of these social workers and persons with other professional backgrounds who find themselves in this professional limbo that efforts have been made to form a professional association centred around an interest in group psychotherapy. This problem will be dealt with more comprehensively in the conclusion of this report, since it is one that affects other non-medical mental health professions.

Chapter 10 Psychology

Introduction and Definitions

It is not easy to characterize the role of psychology in Ontario's mental health services, or to type the professionals who give these services. It is convenient to refer to these professionals as clinical psychologists, so as to differentiate them from experimental, industrial and educational psychologists. Although this terminology is necessary, it can also be misleading. First, the distinction between clinical psychologists and experimental psychologists, for example, may be only one of function and not one of theoretical orientation; it may be both; or it may be neither. Some clinical psychologists base their theoretical orientation on a model of human behaviour that is not in any way different from the model used by the experimentalist in his laboratory. This model is usually Skinnerian, or some modification of it. Other clinical psychologists base their work on the psychodynamic model of psychoanalysis, or some modification of it. Second, industrial and educational psychologists may not be working in hospitals or clinics but nevertheless may be involved in providing services that are part and parcel of community psychiatry, especially in its early warning and preventive aspects. Rehabilitation and vocational counselling services also fall into this twilight zone of indirect mental health service. Since both these and the clinical psychologists receive similar training, it is impossible to make a valid, unequivocal and simple identification either from the nature of their theoretical orientation or from the nature of their work.

To remove some of the distortions of oversimplified definitions, in this chapter special attention will be paid to the functions of psychologists in a variety of different settings, some of which are not narrowly clinical at all but fall within the broad category of applied psychology.

The discussion that follows is limited in that it does not deal directly or in detail with what has been perhaps the most dramatic development in psychology in Ontario since the Second World War — namely, the rapid expansion of departments of experimental psychology in Ontario's universities. Experimental psychology in the universities is, if anything, inhospitable to clinical psychology.

Historical Development

Psychology first emerged as a scholarly discipline in the 1830's in universities within Departments of Philosophy. In fact, the departmental differentiation between

philosophy and psychology has occurred only recently at some universities (such as the University of British Columbia), although it has been of longer duration in Ontario. Some observers suggest that many university psychologists are still trying to live down the recent "philosophical" past of their discipline and even to deny (psychologically) that it ever had such an "olympian", unscientific origin. As we shall see, this process presents problems for the psychodynamically oriented psychologist.

During its first 100 years psychology was occupied mainly with the teaching of knowledge about human behaviour. Because of its close links with philosophy rather than natural science, research in psychology was at first rather intuitive, impressionistic and speculative. A more empirical and experimental approach was to be found among those early psychologists who contributed to the development of the knowledge of the physiology of perception. More recently research in psychology has been directed strongly towards the experimental investigation of behaviour in animals and humans, with emphasis on normal rather than pathological behaviour. Simultaneously a wide range of practical applications of psychology to education, industry and mental health developed, resulting in the formation of a group of applied psychologists who have been providing a wide range of psychological services to the public.

It was not until the 1930's that psychology as a service profession akin to psychiatry, social work, teaching, or law became a matter of serious concern within the discipline. In the U.S. this development has resulted in the formation of two groups of psychologists: the American Psychological Association (APA) and the American Association of Applied Psychology (AAAP). The American Psychological Association is by far the more important body. It bridges the gap between experimental and clinical psychologists. In Canada, the Psychological Institute for the Promotion and Development of Professional Psychology was established in Montreal in 1936. The Institute became one of the foci for the development of professional, as distinct from university research, psychologists in Canada.

World War II accelerated this trend by attracting a large number of university staff into the armed services, where they worked as professional psychologists. Postwar demands for psychology services, particularly in the clinical area, did not abate. In order to face the problems caused by the rapid emergence of the profession, a number of meetings were organized to consider the future of psychology. In the U.S. the Boulder Conference took place in 1949 to study doctoral training programs for clinical psychologists. It was followed by a series of conferences on the training of psychologists in the various applied fields.

Events in Canada moved more slowly. The Opinicon Conference was held in 1960. The original purpose of this conference was to discuss the problem of graduate education and its relation to profession development. But due to restric-

tions imposed by the National Research Council and the Social Science Research Council, which financed the meeting, the issue of professional training had to be ignored.¹ Another attempt to develop professional guidelines was made during the Couchiching Conference organized by the CPA Committee on Professional Problems in 1965. The tasks of the conference were

- 1) To develop a definition of professional psychology in the light of society's needs.
- 2) To clarify objectives of professional training.
- 3) To draft a blueprint for the organizational and financial means necessary for achieving these objectives.²

Among clinical psychologists a considerable degree of uncertainty and disagreement still exists concerning the direction that the development of clinical psychology should take. These are some of the reasons for this uncertainty and disagreement:

- 1) Professional psychology is relatively young, and hence lacks strong traditions and a well-defined professional identity.
- 2) Some psychologists believe that since psychology has not yet developed mechanically applicable, effective procedures for correcting pathological behaviour, its contributions to treatment services in mental health are somewhat in limbo.³
- 3) As a corollary of 2) there is uncertainty as to the nature of appropriate training programs for clinical psychologists in order to equip them with the knowledge and skills necessary to treat psychopathology.
- 4) Medicine, generally, and psychiatry, in particular, have tended to resist the efforts of clinical psychologists to establish themselves in the mental health field as independent psychodiagnosticians and therapists; in Canada this resistance has culminated in the definition by the medical profession of psychotherapy as a medical act.
- 5) Experimental and research-oriented university psychologists (not including clinical psychologists in university departments) have gained control of most university psychology departments and act as an intraprofessional source of resistance to the development of clinical psychology.
- 6) All of these factors add to the difficulties clinical psychologists have in demonstrating convincingly to other mental health professionals

¹Edward C. Webster (ed.), *The Couchiching Conference on Professional Psychology*, Montreal Industrial Relations Centre, McGill University, p. 117.

²*Ibid.*, p. 2.

³Brendan A. Maher, "Training for Professional Psychology", *Canadian Psychologist*, Vol. 6a, No. 1, January 1965, pp. 132-133.

their role in the field of mental health, whether it is as a member of a psychiatric team, as a clinical specialist, or as a private practitioner.

As we shall see at a later point, this situation does not obtain to the same degree in comparable jurisdictions in the U.S., where clinical psychology has enjoyed more rapid growth and has achieved greater stature than it has in Ontario. The reasons for this difference are important, and these also will be discussed later. At this point we must clarify the general nature of the current situation in Ontario.

Psychological Services and their Settings

The work of clinical psychologists involves direct diagnostic, treatment and rehabilitation services to people who suffer from a physical, emotional or intellectual handicap, disability or malfunction. Of the three services (diagnosis, treatment and rehabilitation) more psychologists spent more of their time making diagnoses than performing treatment and rehabilitation together. And often the work done in the areas of treatment and rehabilitation involves *planning* treatment and rehabilitation programs, rather than directly carrying them out. This situation varies greatly from setting to setting, and according to the training background, experience and interests of the individual psychologist as well as according to the policy of the service respecting professional utilization.

The work settings of professional psychologists may be grouped under the following headings: 1) mental health services; 2) alcoholic and drug addiction centres; 3) forensic clinics and reformatories; 4) rehabilitation centres; 5) educational systems; 6) community agencies; 7) industrial and commercial establishments; 8) private practice.

As an introduction to the more detailed descriptions and discussions of the work of psychologists in these different service settings, Table 10.1 presents data concerning the distribution of psychologists as represented by the respondents to the questionnaire sent to psychologists (Study 4).

Nature of the Sample

In 1967 a total of 486 psychologists were registered with the Ontario Board of Examiners in Psychology⁴ resident in the province. Four hundred questionnaires were sent to those psychologists who were believed to be working full time or part time in one or more applied settings. Fifty per cent of these questionnaires were returned. The returns were processed and analyzed, excluding those from psychologists who had given up active practice, or who, because of the nature of their work, found it impossible to complete the questionnaire. Thus, the data for

⁴Personal communication; list of registered psychologists in Ontario provided by the Registrar, Ontario Board of Examiners in Psychology, September 1967.

this report are based on 177 replies from registered psychologists working in Ontario. The questionnaire was divided into sections containing questions on 1) personal characteristics, 2) employment information and principal job activities, 3) the respondent's opinion on licensure, on legal restrictions on the provision of psychological services, and on medical insurance schemes covering such services; 4) training standards; and 5) the respondent's professional activities, such as attendance at association meetings, giving public lectures and scholarly addresses, and producing scientific publications.

Most of the information contained in the sections on employment information and principal job activities is based on the respondents' principal employments, except for eight psychologists whose primary work was in a university and nine who worked in research institutes. These seventeen respondents, however, held one or more secondary jobs in applied settings and analysis of their replies is based on their work in these other settings.

Personal Characteristics

Before presenting the employment data, it may be of interest to know some of the personal characteristics of the respondents. The 177 respondents consist of 116 (65.5 per cent) men and sixty-one (34.5 per cent) women. The largest single age group was composed of eighty-two persons or 46.3 per cent, who were 36-45.

TABLE 10.1
Age Distribution of Ontario Psychologists

Age	Number	Percentage
under 26	0	0
26 - 35	52	29.4
36 - 45	82	46.3
46 - 55	30	17.0
56 - 65	12	6.8
over 65	1	.5
Total	177	100.0

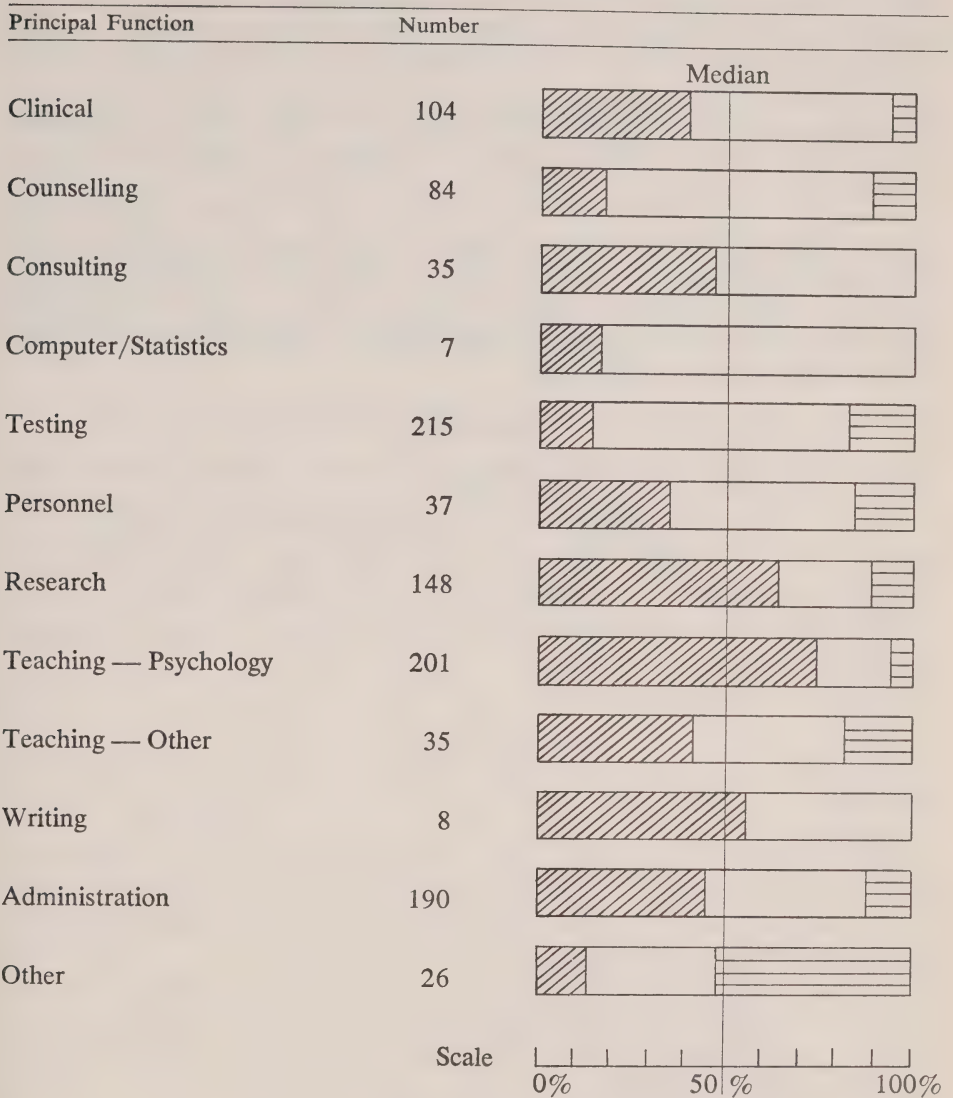
SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967. Based on a questionnaire survey of Ontario registered psychologists.




Educational Characteristics

Only sixty (34 per cent) respondents had doctorate degrees; ninety-three had Master's degrees (M.A., M.Sc., M.P.), while the remaining twenty-four included one M.S.W., one M.B.A., and some who had diplomas in psychology or education.

This highly undesirable situation was brought about by the "grandfather clause" in the Psychologists' Registration Act, 1960, which permitted persons with certain practical experience to become registered. The doctoral requirement is

TABLE 10.2
Percentage of Psychologists in Canada Holding Ph.D., M.A. and B.A. Degrees
According to Principal Function



Proportions of those in each principal work function at doctoral , Master's , and Bachelor's  degree levels.

SOURCE: M. H. Appley and J. Rickwood, *Canadian Psychologist*, prepared for the Scientific Secretariat (Privy Council) of Canada, on behalf of the Committee on Research Financing of the Canadian Psychological Association, 1967.

now in force. The retirement of those who became registered under the special dispensation of the Act will gradually alter the proportion of Ph.D.'s to non-Ph.D.'s until all registered psychologists will have doctorates. Currently many psychologists are not, in fact, on a par with psychiatrists in terms of academic qualifications. This circumstance justifies the dominance of psychiatrists in many mental health services, where the nature of the service itself does not.

A study by Appley and Rickwood relating educational attainment and work function bears out our finding. Table 10.2 indicates that more than half the doctorates are engaged in research, teaching or writing, while only one-fifth of the doctorates are in service functions. The situation is reversed for those with Master's degrees. This circumstance leads to an unfavourable comparison of the educational attainments of Canadian clinical psychologists engaged in service relative to their peers in the United States. In 1964, 60 per cent of United States psychologists in these categories held doctorates compared with 27 per cent of Canadian psychologists in 1966.

TABLE 10.3
Clinical Psychologists by Work Setting and Level of Training, Ontario 1966

Location	Ph.D.			M.A.			Other		
	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total
Psychiatric institutions ¹	21	16	37	53	6	59	37	4	41
Psychiatric units of general hospitals ²	4	6	10	12	9	21	3	5	8
Clinic and outpatient departments ³	16	16	32	59	36	95	25	28	53
Total	41	38	79	124	51	175	65	37	102

¹Total of 40 institutions, made up of:

Mental hospitals, public	14
Psychiatric hospitals, public	5
Hospitals for mentally defective	11
Other, public (ADARF, Thistletown)	2
Private hospitals	8

²Total of 27 psychiatric units, made up of:

Psychiatric units, public general hospitals	25
Psychiatric units, federal hospitals	2

³Total of 66 clinics and outpatient departments, made up of psychiatric OPD's of general hospitals, mental health clinics, child guidance clinics, forensic clinics, OH day care centres, OH outpatient departments, OH children's diagnostic centres, child Adjustment Service, Juvenile and Family Court clinics, mental health clinics for addicts, mental retardation unit of psychiatric hospital.

SOURCE: DBS, *Mental Health Statistics*, Vol. III, Queen's Printer, Ottawa, 1966.

Table 10.3 deals specifically with the question of the educational attainments of Ontario clinical psychologists working in the major psychiatric services (private practice excepted), and it establishes that the Appley-Rickwood conclusions concerning Canadian psychologists apply to Ontario clinical psychologists. These facts explain in part why clinical psychology has failed to establish parity of stature with psychiatry in mental health services. Unfortunately, it is not the sole explanation, because conflict between clinical psychology and psychiatry occurs in the United States also, where highly trained Ph.D. clinical psychologists with postdoctoral training are available.

Work Settings

Over a quarter (26 per cent) of psychologists reported that their principal employment setting is in school systems. Other major employers are general hospitals (10.7 per cent), psychiatric hospitals (10.2 per cent), clinics (8.5 per cent), and industrial and commercial establishments (8.5 per cent).

A high percentage of psychologists work on a part-time basis. Ninety-eight

TABLE 10.4
Distribution of Psychologists by Sex and Place of Employment

Principal employment setting	Male	Female	Total	Total percentage
Psychiatric hospital	15	3	18	10.2
General hospital	9	10	19	10.7
Clinic	7	8	15	8.5
Special clinic ¹	4	—	4	2.3
Reformatory	4	—	4	2.3
Rehabilitation centre	7	4	11	6.2
Student counselling service	—	2	2	1.1
Educational system	26	20	46	26.0
Community agency	3	4	7	3.9
University	5	3	8	4.5
Research institute	6	3	9	5.1
Industry and commerce	15	—	15	8.5
Private practice	9	2	11	6.2
Other ²	6	2	8	4.5
Total	116	61	177	100.0

¹"Special clinic" refers to forensic clinics, and to alcohol and drug addiction clinics.

²"Other" refers to hospitals for the mentally retarded, hospitals for alcohol and drug addiction, government services, and the armed forces.

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967. Based on a questionnaire survey of Ontario registered psychologists.

(55.4 per cent) held a second job outside their principal employment; eleven held two jobs with each demanding an equal share of their working time; twenty-seven held a third part-time job. A few worked in more than three different settings.

The majority of those who reported more than one place of employment are psychologists whose principal employment is in a university (thirty-six) or in private practice (twenty-seven).

Involvement in Mental Health

In order to interpret this information concerning the service placements of psychologists for the specific purposes of this study, it is useful to know how the psychologists in these different settings view the relevance of their work to mental health. Table 10.5 verifies that most psychologists (80 per cent) see themselves as providing mental health services; 11 per cent (approximately) see their work as in no way relevant to mental health, and 9 per cent (approximately) see their work as being partly relevant.

The 80 per cent of the respondents who replied that they consider their work to be related to the field of mental health are mostly psychologists working in psychiatric hospitals, general hospitals, clinics, reform institutions, community agencies and private practice. Most of the 10.8 per cent who gave a negative reply

TABLE 10.5
Relevance of Psychologists' Work to Mental Health

Setting	Yes	No	Partly
Psychiatric hospital	18	—	—
General hospital	18	1	—
Clinic	19	—	—
Reform institution	4	—	—
Rehabilitation centre	8	1	2
Student counselling and educational system	40	2	6
Community agency	6	—	1
University	8	—	—
Research institute	7	1	1
Industry and commerce	3	8	4
Private practice	9	—	2
Other	2	6	—
Total	142	19	16
Total by percentage	80	10.8	9.2

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
Based on a questionnaire survey of Ontario registered psychologists.

to the same question are psychologists working in industry and commerce, and in the "other" category, which includes individuals in the civil service and the armed forces.

Services Provided

It is of value also to have a general picture of the principal work activities of psychologists. To determine the types of work done by psychologists and the amount of time they spent on the discharge of their various duties in different settings, we asked respondents to allocate the approximate amount of time spent on each type of work done within a forty-hour week. Many questionnaires were returned with an indignant exclamation that a sixty-hour week would be more appropriate. Although many psychologists do work more than forty hours per week, for the sake of uniformity this period was used to calculate the distribution of time according to the discharge of functions.

Table 10.6 indicates the amount of time an average psychologist devotes to different functions in different applied settings. Although there is no such specimen as an "average" psychologist, and it is dangerous to base any arguments on such generalizations, the figures shown in this table do give an impression of the similarities and dissimilarities of the functions of psychologists in different settings in Ontario.

In the area of administration psychologists in all settings — except, perhaps, for those in community agencies — are more active in the day-to-day operation of services than in policy decisions concerning mental health programs. With the exception of psychologists in rehabilitation centres, carrying out tests, making assessments and engaging in treatment through behaviour modification form the core functions of psychologists in all settings. Psychologists in general hospitals and clinics devote as much as one-quarter of their time to giving tests and making assessments. Almost two-fifths of the time of psychologists in private practice is spent on the modification of behaviour. Most psychologists have some teaching responsibility, either in academic settings or in applied settings through in-service training programs. Psychologists in school systems devote considerable time (over one-eighth) to consultation with teachers and parents. Apart from psychologists working in rehabilitation centres, very little time is available for research, irrespective of the setting.

The twenty-five replies from psychologists whose principal employment is with universities, research institutes, and civil and armed services have been excluded from this analysis.

Treatment Methods

The questionnaire survey provides a general picture relating treatment to setting and relating treatment methods to each other in terms of the frequency of their

TABLE 10.6
Distribution of Time in Forty-Hour Week by Average Psychologist in Relation to Function and Setting
(per cent)

Function	Psychiatric hospital	General hospital	Clinic	Forensic and addiction clinic	Reform institution	Rehabilitation centre	Educational system	Community agency	Industry and commerce	Private practice
Administration										
1) Policy decisions re mental health	3.0	1.0	1.9	1.5	3.5	1.0	2.0	5.1	0.8	0.8
2) Operation of service	3.5	3.5	3.0	5.0	6.5	5.0	5.5	3.0	7.3	2.3
Tests and assessments	6.1	10.0	10.0	5.0	3.5	1.9	7.5	8.0	6.9	5.3
Modification of behaviour	7.2	6.0	8.0	8.0	6.0	0.5	5.9	1.4	3.0	15.5
Teaching (academic, in-service supervision, instruction, etc.)	4.9	3.2	3.0	3.0	4.0	0.5	4.5	2.6	2.7	3.3
Consultation (with governments, community organizations and other professions in mental health)	2.3	4.5	2.9	2.5	3.0	0.5	5.5	4.3	2.4	2.5
Research:										
1) basic	1.0	0.6	0.2	1.0	—	3.8	0.3	2.0	—	0.8
2) applied	3.1	3.0	0.9	2.5	3.5	3.9	1.4	1.4	3.0	2.6
3) analysis of local service needs for facilities	0.3	0.2	1.2	1.0	2.0	2.5	1.2	0.7	1.1	0.2
Reading (literature re profession)	4.5	3.0	2.0	2.5	4.0	8.6	2.3	2.8	2.4	2.4
Writing (reports, etc.)	3.6	5.0	6.0	4.5	3.0	8.6	3.4	8.7	3.7	2.5
Other (community organization, non-mental health consultation, attending conferences, etc.)	0.5	—	0.9	3.5	1.0	3.2	0.5	—	6.7	1.8

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967. Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.7

Distribution of Psychologists by Treatment Method and Setting

Setting	No. in setting	No. of psychologists engaged in.							
		Counsel- ling	Individual psycho- therapy	Group psycho- therapy	Behaviour therapy	Play therapy	Milieu therapy	Hypnosis	Other ¹
Psychiatric hospital	18	7	11	5	6	3	1	3	1
General hospital	19	10	13	10	2	3	2	—	1
Clinic	15	10	9	4	4	2	8	—	3
Forensic and addiction clinic	4	1	2	2	—	1	—	—	—
Reform institution	4	3	1	2	1	1	—	—	1
Rehabilitation centre	11	9	5	2	—	3	1	1	—
Educational system	48	35	14	14	16	7	2	1	6
Community agency	7	2	2	1	1	—	—	—	—
Industry and commerce	15	10	—	1	—	—	—	—	1
Private practice	11	6	7	5	1	1	1	2	1
Total	152	93	64	46	31	21	15	7	14
Total by percentage	100	61.2	42.0	30.5	20.5	13.8	1.0	0.5	0.9

¹"Other" includes remedial educational programming, skills training, consultation with client's parents and teachers, and environmental manipulation.

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967. Based on a questionnaire survey of Ontario registered psychologists.

use. The twenty-five replies from psychologists whose principal employment is with universities, research institutes, and civil and armed services have been excluded from the following analysis.

The terms "counselling" and "psychotherapy" were not defined in the questionnaire; respondents were allowed their own interpretations. Most respondents made a distinction between the two terms when they answered the question on the percentage of their treatment time spent on specific behaviour modification techniques, as they allocated a separate amount of time for each treatment method. Counselling is the technique most frequently used and is practised by ninety-three (61.2 per cent) psychologists. Individual psychotherapy is practised by 42 per cent and group psychotherapy by 30.5 per cent. Although milieu therapy, play therapy and hypnosis are used by a number of psychologists, such uses are infrequent and they occupy only a low percentage of treatment time. Counselling is used much more frequently. About 40 per cent of the ninety-three psychologists who practise this method spend over half their treatment time doing counselling, and over 20 per cent of them use it as their only method of treatment. Detailed statistics appear in Tables 10.7 and 10.8.

Professional Responsibility for Services

In fact, the question of responsibility is a controversial issue among psychologists. They are divided as to whether or not they should be subject to the direction of the medical profession. In order to find out whether the "cold war" between the psychiatrists and the psychologists is more a war on paper than one in actual practice, we asked psychologists what level of responsibility they have in four areas of work. According to the following analysis, it would appear that psychologists are given a fair share of responsibility in determining a diagnosis, in determining the course of treatment, and in their own case assignments (see Tables 10.9, 10.10, 10.11 and 10.12).

The extent of responsibility and the areas of its exercise vary considerably for different service settings. In carrying out the course of treatment, as many as 80 per cent of the psychologists in community agencies have little or no responsibility at all. This may be explained by the fact that they are not required to give treatment in such settings, since most or all treatment is done by social workers. In other settings where psychologists have a high degree of responsibility in diagnosis and in planning a course of treatment, but little responsibility in *giving* treatment, it is probable that little or no treatment has ever been given to the patients or clients. This is notably so in reform institutions and in school systems. In rehabilitation centres where 27 per cent of the psychologists have little or no responsibility in treatment, most of the patients with symptoms of mental ill-health are not treated within the setting but are referred elsewhere for treatment. The nature and level of training of the psychologists in question also is likely to be significant.

TABLE 10.8
Percentage of Treatment Time Devoted to Various Methods of Treatment

Treatment method	No. of psychologists by percentage of treatment time										Total number using method
	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	
Counselling	10	9	10	9	16	2	2	9	6	20	93
Individual psychotherapy	11	18	7	5	8	3	4	2	3	3	64
Group psychotherapy	15	7	8	4	4	4	—	—	1	3	46
Behaviour therapy	6	4	5	4	4	3	1	1	—	3	31
Milieu therapy	8	4	3	1	5	—	—	—	—	—	21
Play therapy	4	4	3	1	1	—	—	1	—	1	15
Hypnosis	6	1	—	—	—	—	—	—	—	—	7
Other	2	3	3	—	2	—	—	1	1	2	14

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967. Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.9
Degree of Responsibility Exercised by Psychologists in
Determining Diagnosis, by Setting

Setting	All or most	Shared	Little or none	Total number of respondents
Psychiatric hospital	5	8	2	15
General hospital	7	10	1	18
Clinic	5	10	2	17
Reform institution	1	3	—	4
Rehabilitation centre	6	4	1	11
Educational system	30	12	2	44
Community agency	2	2	1	5
University and research institute	3	5	1	9
Industry and commerce	6	—	1	7
Private practice	8	2	—	10
Other	—	3	1	4
Total	73	59	12	144
Total by percentage	50.7	41	8.3	100

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
 Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.10
Degree of Responsibility Exercised by Psychologists in
Determining Course of Treatment, by Setting

Setting	All or most	Shared	Little or none	Total number of respondents
Psychiatric hospital	6	7	2	15
General hospital	2	12	4	18
Clinic	5	12	—	17
Reform institution	—	4	—	4
Rehabilitation centre	4	6	1	11
Educational system	15	27	2	44
Community agency	2	2	1	5
University and research institute	6	3	—	9
Industry and commerce	5	1	1	7
Private practice	6	4	—	10
Other	—	2	2	4
Total	51	80	13	144
Total by percentage	35.4	55.6	9.0	100

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
 Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.11
Degree of Responsibility Exercised by Psychologists in
Carrying Out Course of Treatment, by Setting

Setting	All or most	Shared	Little or none	Total number of respondents
Psychiatric hospital	7	5	3	15
General hospital	4	9	5	18
Clinic	6	8	3	17
Reform institution	1	2	1	4
Rehabilitation centre	2	6	3	11
Educational system	5	24	15	44
Community agency	1	—	4	5
University and research institute	3	5	1	9
Industry and commerce	5	—	2	7
Private practice	7	3	—	10
Other	—	2	2	4
Total	41	64	39	144
Total by percentage	28.5	44.4	27.1	100

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.12
Degree of Responsibility Exercised by Psychologists in
Determining Own Case Assignment, by Setting

Setting	All or most	Shared	Little or none	Total number of respondents
Psychiatric hospital	8	4	3	15
General hospital	8	8	2	18
Clinic	14	1	2	17
Reform institution	3	—	1	4
Rehabilitation centre	7	3	1	11
Educational system	25	17	2	44
Community agency	2	1	2	5
University and research institute	4	5	—	9
Industry and commerce	7	—	—	7
Private practice	9	1	—	10
Other	2	—	2	4
Total	89	40	15	144
Total by percentage	61.8	27.8	10.4	100

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

As is to be expected, psychologists in private practice carry total responsibility for all aspects of their work.

In general, it is in carrying out treatment that psychologists are least likely to carry full responsibility. This finding agrees well with the referral practices of psychiatrists reported in Chapter 4 (Table 4.11).

Professional Cooperation

From Tables 10.9 to 10.12 it is apparent that most psychologists are committed to interprofessional cooperation in carrying out their services. When psychologists were asked for their opinion on coordination and cooperation with the different professions within their own work settings, 51.5 per cent replied that it was successful; 39.5 per cent, partly successful; and 1.7 per cent, unsuccessful. The remaining 7.3 per cent did not give any response.

Psychologists work fairly closely with social workers, psychiatrists, physicians and fellow psychologists. Approximately half the psychologists surveyed have frequent consultations with these professions. Frequency of consultation is slightly less with physicians and slightly more with other psychologists. (See Table 10.13.)

TABLE 10.13
Frequency of Consultation with Other Professions
(per cent)

Frequency	Profession			
	Social workers	Psychiatrists	Physicians	Other psychologists
Several times a week	29.4	26.6	18.1	41.2
Several times a month	20.6	23.8	22.1	17.0
Several times a year	15.0	19.4	27.7	18.7
Rarely or never	17.0	15.1	17.0	9.0
No response	18.1	15.1	15.1	14.1
Total	100.0	100.0	100.0	100.0

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
Based on a questionnaire survey of Ontario registered psychologists.

These data indicate that approximately one-half of the psychologists in the sample are routinely in contact with other mental health professionals in the course of their work. The quality of these contacts is not indicated. Table 10.14 provides some impression of this quality of cooperation as seen by psychologists.

Psychologists feel most comfortable when working with people of the same profession. Over half indicated that their consultations with other psychologists are highly satisfactory, while only one psychologist found such contact to be unsatisfactory. Relationships between psychologists and social workers, and psychologists and psychiatrists also are relatively good. Only 8.4 per cent indicated

dissatisfaction with their consultation with social workers, and 7.3 per cent dissatisfaction with psychiatrists. By comparison psychologists are least satisfied with their consultation with physicians. Only 19.5 per cent answered that they were highly satisfied; 50.8 per cent, fairly satisfied; and 11.3 per cent, dissatisfied.

TABLE 10.14
Degree of Satisfaction with Consultations with Other Professions
(per cent)

Discipline	Highly satisfactory	Fairly satisfactory	Unsatisfactory	No response
Social workers	28.8	43	8.4	19.8
Psychiatrists	25.4	49.9	7.3	17.4
Physicians	19.8	50.8	11.3	18.1
Other psychologists	51.4	32.2	0.6	15.8

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

On the whole the questionnaire responses suggest a more encouraging picture of cooperation than one might expect to find. But there are two disquieting considerations. First, many registered psychologists do not have Ph.D.'s; to what extent, then, is the reported satisfaction based on acceptance of a subservient role by psychologists who, perhaps rightly, feel themselves less well prepared professionally for their work than psychiatrists? Would the same degree of satisfaction be felt by as many psychologists if more of them had doctorates? Second, one important way to improve mental health services is through the close cooperation of general physicians trained in family medicine and psychodynamically trained clinical psychologists. Yet this appears to be precisely where high quality cooperation is most difficult to achieve.

Doctorate Training

As has been noted above, the quality and extent of interprofessional collaboration is governed partly by the level of expertise to which the different mental health professions are educated. Certainly, if clinical psychology as a profession is to achieve something like equality of stature with psychiatry, there will have to be a

TABLE 10.15
Educational Attainments, Ontario Psychologists

Degree	Highest degree obtained	
	No.	%
Master's	93	52.4
Ph.D.	60	36.0
Other (M.S.W., M.B.A., Dip.Ps., Dip.Edu.)	24	13.6
Total	177	100.0

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

TABLE 10.16
University Background, Ontario Psychologists

University	University of Toronto	University of Western Ontario	Queen's University	University of Ottawa	Other Canadian universities	British universities	European universities	American universities	Others	Total
No. of graduates	18	9	5	7	5	4	3	9	—	60
Percentage	30	15	8.3	11.7	8.3	6.7	5	15	—	100

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967. Based on a questionnaire survey of Ontario registered psychologists.

substantial increase in the number who hold Ph.D. degrees, as well as a substantial increase in the number of Ph.D. psychologists who have received high quality training in psychodiagnosis and psychotherapy. At the present time, as Table 10.15 shows, psychologists holding doctoral degrees amount to only 36 per cent. This proportion is considerably lower than that which exists in the U.S., where in 1964 65.9 per cent held Ph.D.'s.⁵

The sixty Ontario Ph.D.'s were obtained at the universities listed in Table 10.16. Although the University of Toronto has had a stronger clinical program (especially in child development) in the past than it now has, it is unlikely that it was ever in a position to qualify for American Psychological Association accreditation. Judging from the criticisms offered by psychologists in field interviews and from the questionnaire survey, it is unlikely that many of the Ph.D.'s in the sample received what they themselves consider to be a thoroughly satisfactory practical training in terms of supervised control cases. On the positive side, it must also be appreciated that statistics on academic degrees attained by psychologists do not give a complete picture of the training received: ninety-three psychologists (52.5 per cent) reported that they have taken additional formal courses relevant to their work since obtaining their highest degree. The most prevalent type of further training was course work towards a Ph.D. degree. Among the 117 psychologists without Ph.D.'s, many have fulfilled all the Ph.D. requirements except the thesis. Other frequently mentioned additional courses taken by psychologists and offered by professional associations, universities and other institutes were in the following areas: personality theory, projective techniques, testing, perception, mathematics, programming, Rorschach scoring and interpretation, parent education, pharmacology, neuroanatomy, neurophysiology, learning theory, sensitivity training, counselling techniques, organic dysfunction, and mental retardation.

⁵"Psychologists in Mental Health", based on the 1964 National Register of the National Science Foundation, U.S. Department of Health, Education and Welfare, September 1966.

When asked whether they would benefit from additional formal courses in the mental health field, 132 (74.6 per cent) psychologists answered in the affirmative. Some of those who answered "no" said that existing courses did not cover their field of specialization.

Attitudes to Training

When asked whether they consider their training to be directed to services in the mental health field, 137 (76.8 per cent) respondents answered "yes", twenty-three (13 per cent) said "no", and eighteen (10.2 per cent) said that it was partly so directed.

Many of those who considered their training to be related to mental health are nevertheless dissatisfied with their professional training standards, particularly with regard to the curriculum of their graduate school courses. The main reason for this high degree of dissatisfaction felt by the respondents, all of whom work full time or part time in one or more applied settings, is that most of the courses offered in Ontario universities are highly experimental in nature and lacking in practical application.

Respondents were asked to list the changes they recommend in the contents of graduate courses. Recommendations were given by the 38.4 per cent who were totally dissatisfied and the 39 per cent who were somewhat satisfied, and even by some who said that they were satisfied with the curriculum in their graduate courses.

These recommendations can be conveniently ordered under a number of general headings.

- 1) Emphasis on applied areas especially in clinical psychology:
 - a) Clinical or medical psychology should have its own program leading to a Doctor of Psychology degree with contents realistic to professional needs.
 - b) More courses relevant to clinical psychology are needed — for example, in group and individual psychotherapy, diagnostic testing, behaviour modification, and interviewing techniques.
 - c) Less emphasis is required on statistical manipulation and experimental theory.
 - d) The appointment of more professors in applied fields is needed.
- 2) Internship programs:
 - a) More internship programs are needed.
 - b) More supervision in internship programs is needed.
 - c) Internship programs should be related to diagnostic testing and treatment, with emphasis on developmental dynamics, personality dynamics, and abnormal psychology.

- d) The preparation of a research thesis by clinical psychologists should be replaced by more thorough internships.
 - e) Internship programs should be approved by the Canadian Psychological Association, with reciprocity with the American Psychological Association.
- 3) More interdisciplinary content and joint training should be established with allied professions in overlapping areas.
 - 4) Additional courses in a variety of subjects, but especially in philosophy and the cultural basis of personality, should replace courses on statistics and experimentation.

These criticisms derived from the questionnaires present a searching critique of postgraduate training in clinical psychology in our universities. They are extremely important for the purposes of this study; for not only do they insist upon reforms, they also offer a blueprint for these reforms. Before leaving this subject, we should consider the extent and quality of internships for clinical psychologists.

Internship is, perhaps, the essential component in the training of a clinical psychologist. Closely related to internship and the decisive determinant of its quality is supervision: the trainee performs diagnoses and treats control cases under the supervision of a senior clinician.

The questionnaires to psychologists showed that during the internship period, student psychologists usually are employed as psychometrists. Their work consists mainly of scoring psychological tests and carrying out evaluations. They receive little training and supervision in counselling and psychotherapy, which are done by most of the psychologists in applied settings. Sixty-four per cent of the psychologists surveyed had no supervised experience, or were uncertain of the number of supervised cases they had had in counselling during their training period; 84 per cent reported the same with respect to casework; and 64 per cent, with respect to psychotherapy.

Clearly some psychologists operate with an exceedingly diluted concept of psychotherapy. Psychotherapy, as it is understood by a competent psychiatrist,

TABLE 10.17
Internship Experience, Ontario Psychologists

	None	No. uncertain	Less than 5	5-10	11-20	21-40	Over 40
Counselling	50	14	7	10	7	6	6
Casework	80	6	1	1	2	4	6
Psychotherapy	53	11	12	10	7	5	2

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967. Based on a questionnaire survey of Ontario registered psychologists.

could not meaningfully allow twenty-one to forty individual case supervisions, let alone forty, as some of the respondents have claimed (see Table 10.17). Time would not permit it, and training would not require it. Even eleven to twenty control cases seems exaggerated. Apparently some respondents have confused psychotherapy with episodic counselling.

The present trend in training seems to place more emphasis on psychologists doing counselling. The more recent graduates seem to have greater availability of supervision in that area (see Table 10.18).

TABLE 10.18
Percentage of Psychologists with some Supervised Experience in Specialized Areas, by Date of Graduation

Graduation date	Total no. of graduates	Graduates with supervised experience					
		Counselling		Casework		Psychotherapy	
		No.	%	No.	%	No.	%
Before 1937	6	0	0	0	0	0	0
1937-1949	27	6	22.3	5	18.5	7	26.0
1950-1962	133	52	39.1	19	14.3	53	39.9
After 1962	11	5	45.6	1	9.1	4	36.4

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

To what extent the shift from psychotherapy to counselling reflects a real difference and to what extent it reflects a change in terminology is not clear. Medicine has worked hard to claim possession of the word "psychotherapy". Psychologists have reacted by adopting the term "counselling" to refer to both counselling and psychotherapy.

The assessment of postgraduate training in psychology by registered psychologists indicates a widespread feeling that substantial improvements are mandatory. Entrance requirements generally are found to be acceptable, but the curriculum is not. Only 12 per cent of the respondents indicated that they were satisfied with the present psychology curriculum in graduate schools in Ontario (see Table 10.19).

TABLE 10.19
Evaluation of Postgraduate Training in Psychology

Area	Satisfied		Somewhat satisfied		Dissatisfied		No response	
	No.	%	No.	%	No.	%	No.	%
Entrance requirements	90	50.9	53	29.2	13	7.4	21	12.5
Curriculum	22	12.4	69	39	68	38.4	18	10.2

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
Based on a questionnaire survey of Ontario registered psychologists.

It is an important fact — one that must not be lost sight of — that the major criticisms made by clinical psychologists of their training closely parallel the major criticisms made by psychiatrists of theirs. There are exceptions, of course, but the majority of psychiatrists and psychologists are in agreement concerning the need for training reform.

Attitudes on Major Professional Issues

Administration and Interpretation of Psychological Tests

The results of the survey show that, while the medical profession is defending its traditional monopoly on rendering therapeutic services, the profession of psychology seems to be equally wary of its right to administer and interpret psychological tests. As Table 10.20 shows, 85.3 per cent of psychologists think that registered psychologists with special training in this area have the qualification and should have the legal responsibility to collect and interpret psychological assessment data; 61 per cent give the same right to all registered psychologists; and 31 per cent would allow it to psychometrists and other non-registered persons trained in psychology. By contrast, social workers are favoured by only 3.4 per cent of the respondents, psychiatrists by 7.4 per cent, and physicians by 0.6 per cent.

TABLE 10.20
Attitudes Concerning Testing by Other Mental Health Professionals

Discipline	Number (Total = 177)	Percentage
Social workers	6	3.4
Psychiatrists	13	7.4
Physicians	1	0.6
Registered psychologists with special training	151	85.3
Registered psychologists	108	61.0
Psychometrists	55	31.0
Persons under supervision	10	5.6
Other	2	1.1

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
Based on a questionnaire survey of Ontario registered psychologists.

The results of the questionnaire survey also underline the disagreement among psychologists over the question of legislative control. Asked whether they would favour a licensing act which would make illegal the rendering of psychological services by unlicensed persons, 57.6 per cent answered “yes”, 25.4 per cent were against the introduction of such legislation, and the remaining 17 per cent gave no opinion.

Many who object to licensing find an alternative in restricting by law certain psychological testing and behavioural modification techniques, so that such

procedures would not be abused. Such legislation is acceptable to 63.3 per cent of psychologists; 18.6 per cent are against it; and 18.1 per cent did not respond to the question (see Table 10.21). Those who favour legislative control argue that the interpretation of tests and treatment through behaviour modification can have dramatic effects on the future mental health of subjects. This is dangerous when clinics and schools can buy test materials to be used casually by untrained people such as school teachers. Psychologists want to restrict the following procedures: all individual psychological tests; personality appraisals; traumatic conditioning; therapy of any type, especially psychotherapy; counselling; and hypnosis.

TABLE 10.21
Attitudes Towards Licensing and Legal Control of Services

Issues	Yes		No		No opinion	
	No.	%	No.	%	No.	%
Licensure	102	57.6	45	25.4	29	17
Legal control of services	112	63.3	33	18.6	31	18.1

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
Based on a questionnaire survey of Ontario registered psychologists.

The 18.6 per cent who answered "no" to legal control indicated that tests and treatment touching on mental health are very broad areas, undertaken by many people — teachers, clergymen, physicians, lawyers and others. It is impossible, therefore, to define or effectively restrict the practice of such procedures until the various professions have become more scientific in their approach to mental health.

The Practice of Psychotherapy

In reply to the question, "Who should be allowed to practise psychotherapy, considering their training and legal responsibility?" 89.3 per cent of the respondents would give this right to registered psychologists with special training in this area; 93.8 per cent, to psychiatrists; 57.6 per cent, to social workers; 27 per cent, to all registered psychologists; and only 20.3 per cent, to physicians (see Table 10.22).

The majority of psychologists take the view that social workers, psychiatrists and psychologists with proper training can engage competently and safely in psychotherapeutic work with patients in hospitals, clinics and private practice.

Coverage by Prepaid Insurance Schemes

Sixty-five per cent of the psychologists in the survey held the opinion that medical insurance schemes should cover services provided by professional psychologists without medical referral. The 23.8 per cent who do not desire such coverage is made up of 4 per cent who think that psychological services should be covered only if they are provided to patients on medical referral, and 19.8 per cent

TABLE 10.22
Opinions Concerning the Practice of Psychotherapy by Other
Mental Health Professionals

Discipline	Number (Total = 177)	Percentage
Social workers	102	57.8
Psychiatrists	166	93.8
Physicians	36	20.3
Registered psychologists		
with special training	158	89.3
Registered psychologists	48	27.1
Psychometrists	7	3.9
Lay analysts, clergy, etc.	19	10.7
Other (teachers, lawyers, etc.)	15	8.5

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
 Based on a questionnaire survey of Ontario registered psychologists.

who feel that coverage by *medical* insurance schemes would continue to make psychology a paramedical discipline dependent on medicine. The former 4 per cent would have no objection to coverage if services were provided on medical referral; the latter 19.8 per cent would be in favour of coverage by insurance schemes which do not bear the name "medical" or which are designed especially to cover professional psychological services.

The implications of this issue will be considered below.

Publications

Clinical psychologists experience a conflict between two professional responsibilities: clinical work and research. This conflict will be examined in more detail below, but Table 10.23 provides a picture of the research activity of non-university registered psychologists.

The psychologists in the sample were somewhat more actively involved in giving public talks and lectures than in publishing research.

TABLE 10.23
Publication of Research by Non-university Registered Psychologists

Area	None		No. un- certain		Less than 2		3-5		Over 5	
	No.	%	No.	%	No.	%	No.	%	No.	%
Clinical										
psychology	138	78	4	2.3	27	15.1	7	4	1	0.6
Other professional										
areas	128	72.4	4	2.3	31	17.4	12	6.8	2	1.1

SOURCE: C. Hanly and J. Wong, Mental Health Survey: Psychologists (Study 4a), 1967.
 Based on a questionnaire survey of Ontario registered psychologists.

On the question of whether they had given any public talks or lectures during the past year, sixty-three (35.6 per cent) answered that they had not; eleven (6.2 per cent) had given some, but were uncertain as to exactly how many they had given; thirty (17 per cent) had given less than two; thirty-six (20.3 per cent) had given between three and five; and thirty-seven (20.9 per cent) had given more than five such talks.

There is a great need for general public education in the field of public health. Lectures and seminars on problems of children at various age levels are welcomed by many parents who are looking for more knowledge and better insight. But this kind of contribution to knowledge, however much it may be respected and admired by university psychologists, does not substitute for the presentation of research results in papers at scientific meetings. It is unrealistic to expect that most clinical psychologists can combine top flight clinical work with research activities that are competitive with those of university psychologists.

Affiliation with Professional Associations

Psychologists do not appear to be as committed to their professional associations as psychiatrists. From this we can draw three conclusions: 1) psychologists, like their academic confreres, tend to be highly individualistic; 2) they are not as subject as psychiatrists to professional policy demands imposed upon them by their professional association; 3) they are not as subject as psychiatrists to ethical demands imposed upon them by their professional association.

In field interviews a number of psychiatrists stated that, irrespective of their personal views, they would not take public exception to a policy position of their association as long as the position was the result of a considered examination, with all points of view being given a fair hearing. The policy concerning the nature of psychotherapy is an example. Psychologists appear to have a rather looser, less disciplined affiliation to their professional association. From the quantitative point of view, of the 177 respondents to the questionnaires 113 (64 per cent) said that they are members of the Canadian Psychological Association, while 133 (75 per cent) are members of the Ontario Psychological Association. A few who belong to neither said that they are members of the American Psychological Association. Some criticized the associations for not being representative of the small interest groups — for example, of industrial psychologists.

As measured by the frequency with which they attend meetings, many of those who are members do not take an active part in their association. Eleven psychologists (6.2 per cent) answered that they never attend such meetings; eighteen (10.2 per cent) answered that they rarely attend; forty-seven (27.6 per cent) attend once every few years; fifty-three (30 per cent) attend about once a year; and forty-six (26 per cent) attend more than once a year.

Earnings

The greater earning power of the medical profession generally, and of psychiatrists in particular, is a factor that contributes a steady, powerful, if sometimes unacknowledged, pressure against equality of professional stature. This factor is irrational in the sense that it may have nothing to do with training qualification, aptitude, skill and experience, or merit of service. But it is none the less real for being irrational.

As Table 10.24 shows, the salaries of the psychologists in the sample compare favourably with those of teachers, including university teachers; but they are considerably lower than the earnings of physicians. Aside from the fifteen psychologists whose principal employment is not calculated on a full-time basis, fifty-four (30.5 per cent) earn between \$12,000 and \$13,999 per year; only one psychologist reported to be earning less than \$8,000; and nine (5.1 per cent) reported an annual salary of \$18,000 or over. It will be noticed that thirty-five of the respondents did not complete the section on salaries.

TABLE 10.24
Salaries, Ontario Psychologists

Salary range	No. of psychologists	Percentage
Under \$8,000	1	0.5
\$ 8,000 - \$ 9,999	8	4.5
\$10,000 - \$11,999	30	17.0
\$12,000 - \$13,999	54	30.5
\$14,000 - \$15,999	30	17.0
\$16,000 - \$17,999	10	5.6
\$18,000 and over	9	5.1
No. reporting salary	142	80.2

SOURCE: C. Hanly and J. Wong, *Mental Health Survey: Psychologists (Study 4a)*, 1967.
Based on a questionnaire survey of Ontario registered psychologists.

The next section considers the typical services in which registered psychologists work. Their functions, responsibilities and interprofessional relationships vary a good deal according to the service (mental hospital, community mental health clinic, or educational system) in which they work. The degree to which the work contributes directly to mental health also varies according to service setting.

Service Settings

Hospitals and Clinics

Mental health services are provided in the Ontario Hospital system, in community psychiatric hospitals, in psychiatric units of general hospitals, in community mental health clinics, and in child guidance clinics. The Brief of the Ontario Psychological Association to the Committee on the Healing Arts summarizes the functions of clinical psychologists in these settings as follows:

- 1) Psychological assessment, including diagnosis of mental disorder, state of mental health, intellectual and other abilities; evaluation of perceptual and central nervous system functional impairment, and of vocational potential for rehabilitation.
- 2) Individual and group psychotherapy, application of techniques of behaviour modification, planning therapy programs, formulating rehabilitation programs.
- 3) Evaluating ongoing programs of treatment and care.
- 4) Conducting theoretical as well as applied research studies.
- 5) Education and training of psychology candidates and other professions in training.

But psychologists perform all of these functions only in places where the working climate is favourable. In making psychological assessments and diagnosis, the psychologist may be part of an intake team, or he may have cases referred to him by the psychiatrist in charge. In either case, the major role of the psychologist is to carry out psychological tests, and to make assessments and evaluations which will contribute to an accurate diagnosis and the planning of a course of treatment. The psychiatrist or other physician in the service is legally responsible for diagnosis and treatment, even though the psychologist may be responsible in practice. The psychologist may participate in planning, as well as conduct ward programs and different kinds of therapy, including group and individual psychotherapy and behaviour therapy.

When the hospital is a teaching hospital or when the clinic is a field placement agency for students of different health disciplines, the psychologist may instruct and supervise them. He may also do some research in his field. Because of the chronic shortage of sufficient personnel in the diagnostic and treatment services, however, opportunities for research are limited.

In fact, it is only rarely that we find work settings where the psychologist is providing all of these services. Where there is adequate staff, the psychologist has more freedom to devote himself to an area in which he is more interested — such as research, or developing special therapeutic programs. But in most hospitals and clinics the psychologist would be doing only the first of the five functions listed above.

Some psychologists in these services take the view that testing methods for the purpose of making an accurate diagnosis are clinical psychology's unique contribution to mental health. Other services that they might perform can be done equally well by psychiatrists and social workers. Because these tests cannot be administered and interpreted as well or even adequately by other professionals, these psychologists are satisfied to devote the major part of their time to giving tests and making assessments. However, they do object to some of the conditions under which they are obliged to work. Specifically:

- 1) They object to being asked by psychiatrists to carry out specific tests which they feel are irrelevant to the case in question, or being asked to carry out specific tests without being meaningfully involved in the case.
- 2) They object to having the test results used by the psychiatrist in making a diagnosis and settling on a treatment program without further consultation about their interpretation and application. This practice is all the more unsatisfactory to clinical psychologists if followed by general practitioners who know little about abnormal behaviour and interpreting tests — not only because they dislike being patronized, but because the test data may not be most effectively or properly used in the best interests of the patient.
- 3) They object to the failure by the medical staff to use information gathered by the psychologist from routine tests and assessments. This is often filed away without being studied and used, or is used only to confirm conclusions already reached by the medical staff.
- 4) They object to the lack of adequate opportunities for follow-up of patients they have diagnosed because the psychiatrists do not consider them part of the therapeutic team.

The main obstacle to the achievement of a satisfactory professional role, according to many psychologists in these services, is the dominance of the medical profession. A physician is chief of administration (this circumstance is now changing in Ontario Hospitals as it has changed already in general hospitals); a physician heads the treatment team; the physician's authority is sanctioned by law; and rarely are there autonomous psychology departments in hospitals to act as an institutional buffer.

Institutional change can remedy some of the defects in the existing system. One potential for improvement is the reorganization of the administrative structure that is now under way in Ontario Hospitals; as a result of this the chief administrator of the hospital need not be, and in most cases will not be, a doctor. With the addition of departments of psychology and a chief of psychological services, psychologists might find themselves in a more congenial administrative structure. There are two reasons for expecting benefits from these structural and personnel changes in administration. First, highly developed psychiatric hospitals, such as the New York Psychiatric Hospital attached to the Columbia Presbyterian Hospital in New York, have departments of psychology with a clinical psychologist as head who is in a position of sufficient authority within the hospital decision-making hierarchy to remedy problems encountered by psychologists on his staff. Second, in the psychiatric units of general hospitals which have adopted such an administrative structure the position of psychologists has improved. For example, in the case of a new psychiatric unit being developed in a large general hospital in Ontario, the psychologists wanted to establish psychological services in the hospital in order to provide diagnostic, treatment and research services, and to

have a practicum setting for graduate students. The psychiatrists were quite resistant to the proposal when it came down to working out practical details, although they accepted the idea in theory. The hospital administrator, who had no professional investment in the situation on either side but wanted the best possible services for the hospital, was quite prepared to establish psychological services as quickly as possible. Perhaps the eventual outcome would not have been different; but undoubtedly under a physician administrator, there would have been many difficulties and delays. In any event, a clinical psychologist has been appointed as head of psychological services in the hospital, and he holds a cross-appointment to a local university department.

Clinical psychologists have voiced the opinion also that by training and experience they are often qualified to assume responsibility for the administration of wards in psychiatric as well as general hospitals. They do not claim to be competent to deal with the strictly medical aspects of ward service; but they feel that, with the cooperation and assistance of physicians, who could undertake their usual responsibility for the medical care and treatment of the patients, senior psychologists could supervise the overall treatment program of the ward. There are only isolated cases where psychologists have been given this responsibility. One such is R. A. Steffy, who administers a ward at the Lakeshore Psychiatric Hospital. Steffy's work has been praised widely by the psychiatrists and psychologists we interviewed.

Two questions arise. Is it the shortage of psychologists that results in their absence from positions of leadership in hospital services? Or is it their absence from positions of leadership in hospital services (medical monopoly) that results in the shortage of psychologists?

Alcohol and Drug Addiction Centres

The Alcoholism and Drug Addiction Research Foundation will be described in detail in Part Three. We are concerned here only with the functions of psychologists in the various divisions of the Foundation. Because they are research, diagnosis and treatment centres, they provide an environment particularly congenial to psychologists. Further, the role of medicine varies from centre to centre. In some divisions of the Foundation, particularly in the Research Unit, psychologists have leadership roles. Nevertheless, in the Clinical Services Division psychologists, while playing some part in therapy, are occupied mainly with diagnosis only. Of all the Regional Units, the Lake Erie Region, with its headquarters in London, is the only unit which has a psychologist as its regional director. There is one other Ph.D. in psychology and one psychometrist working under him.

There is a significant difference in the approach to therapy of psychologists working in this field. Some employ behaviour therapy premised on learning theory and conditioning; others adopt a psychodynamic orientation. This difference is found also among psychologists working in hospitals. With the exception of the

Lake Erie Regional Unit and some of the Research Units, the role of psychologists here is quite similar to that of psychologists in hospitals, with a strong emphasis placed on diagnosis and assessment and a lesser involvement in treatment.

Reform Institutions

The Department of Reform Institutions provides a number of different types of custodial institution. Sentenced offenders will be sent to one or other of these according to a number of criteria, including the nature of their personalities, motivations and psychological needs. Consequently, the Department has and needs a psychological testing and assessment service. This service is provided primarily by psychologists; psychiatrists play a supporting role, restricted largely to consultations with criminals suffering from a psychosis or from a gross psychopathic condition and in need of treatment at a mental hospital or confinement in the prison for the criminally insane at Penetang.

At the time of writing there were twenty-four posts for psychologists in the Department's training schools and reform institutions. In February 1968, the Department of Reform Institutions had only eight psychologists for these posts; eight positions were occupied temporarily by psychometrists, and eight were vacant.⁶ Reform institutions have a total admission of over 10,000 each year. The work of evaluation and assessment, however routine, keeps the psychologists so busy that they have little time for therapeutic and research work. The situation is further aggravated by chronic vacancies. There is great difficulty in recruitment — a difficulty which could be due partly to the general manpower shortage and partly to the unattractiveness of reform institutions as a work setting.

One answer to this problem is the use of psychometrists to perform diagnostic and testing functions in such settings. According to the supervising psychologist for the Neuropsychiatric Clinic and the Guelph Reformatory, psychometrists make a most important contribution to the work of the psychological services in reform institutions. They give tests and interpret the results in relation to the life history of the prisoner, and they prepare comprehensive reports on which the treatment of each inmate is based while in custody. But there is equal difficulty in attracting psychometrists, because of the limitations placed on their pay ranges and career opportunities. Psychometrists are not eligible for registration under the Psychologists' Registration Act as they have not received a sufficiently advanced training (Ph.D.) to qualify.

The Alex G. Brown Memorial Clinic at Mimico is the only reform centre where psychologists are engaged more in treatment than in assessment. On staff are five psychologists and two psychometrists. The clinic offers intensive treatment for alcoholics, drug addicts and pedophiles, and the bulk of the treatment is

⁶Personal communication, W. A. Norton, Director in Psychology, Ontario Department of Reform Institutions.

given by the psychological staff. They conduct individual and group counselling, group therapy, recreational and didactic programs, and behaviour therapy. Behaviour therapy is performed with the cooperation of the Lakeshore Psychiatric Clinic, under the direction of R. A. Steffy.

If there is a shortage of psychologists in the Department of Reform Institutions, there is an even greater shortage of psychiatrists. Consequently, this service area provides an opportunity for psychologists to advance to senior supervisory positions, and to experiment with treatment programs with an orientation determined by psychologists rather than psychiatrists. Several clinical psychologists have mentioned that the Galt Training School is a good example of this kind of opportunity. The director of the treatment program at the Galt Training School is Robert Ross, adjunct professor of clinical psychology at the University of Waterloo and chief psychologist at the Galt Training School. Ross has inaugurated a treatment program based on the theoretical orientation of behavioural psychology. He works in close cooperation with a psychiatrist and an internist who is the medical director of the Galt Training School. The Galt Training School thus presents an example of successful professional collaboration between psychology and medicine when they function together on an equal footing. It also provides an experimental setting for the application of these behaviour modification techniques in detention institutions.

Rehabilitation Centres

Rehabilitation centres are of two kinds: those for the physically disabled, and those for the mentally disabled. Psychologists in these services usually assume total responsibility for their patients in assessment, treatment and referral. The Jewish Vocational Service (Toronto), for example, employs six psychologists. They operate a rehabilitation service for discharged mental patients. Patients usually are referred to them by mental health institutions and other psychiatric agencies. Because of the referral system, the service is linked to medical services and thus, in effect, receives patients who have already been medically examined. The main task of the JVS is the vocational rehabilitation of these patients. The patient spends a period of from six weeks to six months at the JVS (non-residential), during which time the psychologist explores his work ability and prepares him for employment. The patient does not learn a specific skill at the JVS, but he learns behaviour patterns (punctuality, patience and tolerance) which will make him acceptable to the society to which he is returning and which will help him to keep a job.

Psychologists working in rehabilitation centres for the physically disabled are involved only indirectly in the mental health field, insofar as physical disability may have affected the patient mentally, or if the person who is physically disabled happens to be suffering also from a mental disorder. Where such problems occur, the patient may be treated by psychologists working at the centre or he may be

referred to a psychiatric service for treatment, depending on the practice of the rehabilitation centre. The Rehabilitation Centre for the Disabled is unique in that it is directed by a psychologist and is primarily a psychological agency. Occupational therapists, social workers and physicians are present only as consultants. The work of the psychologist consists of assessment, testing, counselling (vocational); the administration of rehabilitation workshops; the training of other staff and university students; the supervision of occupational therapists and others; and referrals to schools and other psychiatric and medical services. There are not a few patients with mental problems, but these are all referred to psychiatric services for treatment. In the Rehabilitation Institute of Ottawa, which provides similar services for the physically handicapped, psychologists carry out tests to determine the emotional reactions of the patients to their disabilities; they make assessments in an attempt to work out these problems with the patients. Where mental problems are serious or where long-term treatment is needed, the patient is referred elsewhere for treatment.

Educational Systems

It is well known that a large proportion of psychologists are employed by educational establishments. According to the Register kept by the Ontario Board of Examiners, 23 per cent of the psychologists registered with the Board were engaged in university teaching at the time of registration.

Since this report does not include psychologists in academic settings, our category of psychologists in educational systems contains only those who are employed as student counsellors in universities and as educational psychologists in secondary and primary school systems. Although there is no exact measure of the number of psychologists employed by school boards in Ontario, Table 10.4 shows that as many as 26 per cent of the returns come from registered psychologists whose principal place of employment is in the school system.

The work of educational psychologists is very different from that of the clinical psychologists. Most of them are eager to dispel the image that they are clinicians. They define their area of interest as educational problems — such as specific learning problems, underachievement, adjustments to the social system of the school — rather than as mental ill-health problems, such as neurosis and psychosis. Because of this, they are less concerned with psychiatric liaison or direction. The same terms used by clinical psychologists have a different meaning to educational psychologists, who think of “diagnosis” in terms of analysis of a problem situation (such as underachievement) and “treatment” in terms of an educational process (such as remedial mathematics instruction). Although some educational psychologists also do counselling and psychotherapy, and administer tests, most feel that they do not require a clinical background for their work but that a learning and educational psychology background may be more appropriate. The majority of educational psychologists believe that their best and most useful function is to act

as a consultant to teachers, principals and other school administrators in the handling and teaching of pupils with cognitive, perceptual and personality handicaps. The educational psychologist is trained to act as a consultant also in the design of preventive programs, in educational technology, in curriculum planning, and in the broad needs of normal children in classroom learning.

Very often, however, the educational psychologist finds that he is providing direct service to individual children and that he spends most of his time administering psychological tests to school children in order to diagnose behaviour, emotional or general learning problems. Less often does he act in the broader consultative and planning functions which appear to be his preference and for which he feels his training best suits him. The explanation for this situation is not hard to find. Neurotic disorders are among the most common psychiatric disorders in the population. But they do not develop suddenly in adulthood *ex nihilo*. An adult neurosis has a history reaching into childhood. Children who are undergoing this process today will make up tomorrow's 15 to 20 per cent of the adult population with significant disabilities from neurotic disorders. These children present emotional, behavioural and developmental learning problems in the classroom. Since it is impossible for the teachers to deal with them effectively, and since their families have already failed, these children are brought to the attention of psychologists in the hope that they can obtain help. Unfortunately, with scarcely any exceptions, educational psychologists are trained only to administer diagnostic tests; and when they find that the problem is emotional, as they often must, they are not equipped by training to treat these disorders. Consequently, they must be satisfied with referring them elsewhere for treatment, fully realizing that the children will receive no treatment at all because the community lacks clinical resources.

A second unsatisfactory aspect of psychological services in the school system is that tests and procedures for assessing mental and emotional characteristics often are carried out by school teachers who, at the most, have taken only a short course in psychology and psychometry. Psychologists insist that, while some tests can be administered and scored by people with lesser training, the derived data and their relationship to the problem involved must be interpreted (or the interpretation must be supervised) by a qualified psychologist. The same applies to the counselling work that is being done by "school guidance teachers" who have had only a year's training in the related fields.

It appears that educational psychologists are somewhat isolated, not only from persons of their own profession but also from their colleagues in their own work setting — that is, from teachers, inspectors and other guidance personnel. Because these disciplines know relatively less about human behaviour, they feel threatened by the presence of psychologists, whom they consider as "outsiders" and whom they seldom consult. It is therefore difficult for psychologists to break into the rigidly structured teacher-principal-inspector-superintendent system.

The same experience has been reported by at least one of the very few psychiatrists who work in the school system. The attitude appears to be that social workers, psychiatrists and psychologists are in the school system but not really *of* it; it is felt that officials and administrators would be relieved if these people would quietly go about the business of removing all of the behaviour and learning problems, and leave everyone else undisturbed. But it is also found that the classroom teachers are keen to learn how to recognize, understand and manage more effectively the emotionally disturbed children in their classes, and to cooperate fully with the professionals who are able to help them.

One can exaggerate the extent to which psychologists in the school system are performing, or deem themselves competent to perform, a diagnostic service relevant to psychiatric disorders. Most of the educational psychologists who responded to the questionnaire survey (Study 4a) considered that their work contributed directly to the mental health fields (Table 10.5). But the survey of school boards (Study 5) presented a rather different picture. Not all of these questionnaires were completed, but many of them were, and a typical pattern of responses to the specifically psychiatric content of the questionnaire emerged. This content included data concerning the number of children served by the psychological services of the school board who had been diagnosed as suffering from a psychiatric disorder, and data concerning the type of psychological treatment employed. Because psychologists in the school system do not use psychiatric categories for classifying or understanding the problems of school children, in almost all cases they stated that the diagnostic question did not apply to them at all. In practice they reach a description of the problem behaviour that is as precise as possible without any analysis of the possible origin in a disturbed psychological process in the psychiatric sense. The focus is on more superficial, manageable aspects of the problem (such as study habits and peer relationships) and on specific learning disabilities (such as organic auditory or visual defects). And the object is to manipulate the environment in order to assist the child with the problem, or to provide him with counselling so that he can manage his problem at a conscious, reality-oriented level. Thus, just as diagnosis in the psychiatric or clinical sense is deemed to be inapplicable to themselves by these psychologists, so is treatment in the psychiatric or clinical sense. The closest they have come to treatment in the strict sense is to recommend special classes for children with learning handicaps, or to engage in some counselling designed to assist the child in solving a behaviour or learning problem. In all cases the problem must involve some kind of failure in learning or adapting to the school environment; other personal problems of development and family life do not appear to concern the educational psychologist.

Community Agencies

Psychologists work in welfare and family service agencies, and in community organizations. But in agencies where social work is the dominant profession, either

in administration or in orientation, psychologists are seldom found. Psychological services are required by these agencies only in testing and assessment. The agencies usually make use of facilities in local mental health clinics, in rehabilitation centres, or on school boards. Social workers seldom refer clients to psychologists for therapeutic services, because they are disinclined to promote the psychologists' therapeutic capabilities as being superior to their own or even as being valid substitutes for their own casework.

In community organizations such as the YMCA Counselling Service, the main task of the psychologist is in vocational counselling of adolescents and adults. He appraises the client's potential based on a psychological measurement of his interests, aptitudes and intelligence, and counsels him on the choice of a career or on the handling of personal and social problems. The majority of these clients are deemed mentally normal people, although there are some who have symptoms that need a more intensive counselling which many psychologists would call psychotherapy. Some even consider that they are, in effect, treating mental illness, although most of their clients are not on medical referral.

Industrial and Commercial Establishments

Industrial psychologists include psychologists in the armed services, those employed by large industrial concerns, and those who act as consultants to industries, either as private practitioners or as employees of consulting firms. The scope of work is very diversified and includes personnel selection, placement, training and counselling, marketing research, advertising and consumer testing, production planning or operational research, labour management and public relations. These functions do not come into the area of mental health, except perhaps when psychologists are helping to solve personnel problems in the form of counselling and vocational guidance for individuals. One psychologist who acts as a private consultant commented that work in industrial settings is very unsatisfactory because of the impersonal approach adopted by industrial establishments. The psychologist is not able to do any follow-up after individual employees have been evaluated and tested. He feels that such an approach is not a legitimate one for psychologists, and that much of the work done, for example, in time and motion studies can be left to engineers.

Private Practice

There are very few psychologists in Ontario who are primarily self-employed. However, many work in hospitals, universities and school systems and devote part of their time to private practice. Depending on their location and the number of hours per week they spend in private practice, the case load of the psychologist in private practice ranges from fifteen to over fifty per week.

Clients are usually referred by physicians and psychiatrists with whom the psychologist is connected in hospital work. Other sources of referral include community agencies, lawyers, clergymen and self-referrals.

The work of these psychologists is focused on the assessment of aptitudes and intelligence, on vocational counselling, and on working with clients towards the solution of social problems. In vocational counselling, the majority of the clients belong to the teenage group who are not doing well in school because of mental health problems. Clients who belong to the twenty-five to thirty age group usually have problems in social, marriage, or parent-child relationships. In serious cases, these problems may have affected them so deeply that they are unable to function normally, and they may be classified by the psychologist as neurotic. These patients usually come for treatment once every week or every two weeks for a period of from six months to over two years. The psychologists interviewed said that they see some psychotic patients, but that these persons are never treated by them. When the psychologist suspects that a client is suffering from a psychotic disorder, he consults the family doctor, who can assume the responsibility of referring him to a psychiatric hospital or clinic. If the client does not have a family doctor, the psychologist will refer him directly to a psychiatrist or to a mental health clinic.

The private psychologist consults often with a psychiatrist and with a physician. The psychiatrist he consults is usually known to him personally. Very often the psychiatrist or the physician he consults has his office in the same building. Supervision by psychiatrists is nominal in the relationship and does not represent any threat to the psychologist's autonomy as a professional person.

To date there have been two teams of psychologists and psychiatrists engaged in group private practice, one in Toronto and one in Hamilton. Collaboration between the two professions within the groups was reported to be highly successful. One other group, which had existed for eleven years, had to be discontinued; as psychologists were not paid by OMSIP and PSI for their clinical work, the group became financially unworkable.

Of the five psychologists in private practice interviewed, four had Ph.D. degrees in psychology, while the fifth had completed all his Ph.D. work except the thesis. None of the five psychologists had a psychometrist or technician working under him, and none found that he needed auxiliary personnel in his office.

Private practice in clinical psychology is much more common and more highly developed in comparable American states than it is in Ontario. Groups of clinical psychologists and psychiatric social workers in association with psychiatrists have formed mental health clinics. An example of such a clinic is the Community Guidance Service in New York. This clinic is chartered under state law administered by the Department of Mental Hygiene. The law requires that the clinic have a number of psychiatrists on staff, at least in a consultative capacity. In 1966 the clinic had five psychiatric consultants who undertook diagnostic responsibilities and who were responsible for dispensing drugs whenever they were required. However, the bulk of the clinic's work is done by social workers and psychologists. In 1966 the Community Guidance Service conducted

about 20,000 session hours of psychotherapy and saw about 600 patients over the year, with approximately 300 patients being in treatment at the clinic at any one time. Treatment is restricted to individual and group psychotherapy to neurotic patients. Direction of the clinic is in the hands of clinical psychologists.

A similar private group practice is the Washington Square Mental Health Clinic in New York. The director of the clinic is a psychiatrist. This fact reflects the much closer collaboration and greater involvement of psychiatrists with clinical psychologists and social workers in this clinic, as compared with the Community Guidance Service. Nevertheless, psychologists and social workers outnumber psychiatrists. The psychiatrists are uniquely responsible for medical diagnosis and for dispensing any medications that may be required. As a rule, though, the clinic does not take patients who are in need of medication. The Washington Square Clinic is licensed by the Board of Regents of New York State.

There are about twenty such clinics in the New York area and they have been joined together in an organization called the Federation of Mental Health Clinics. This organization does not regulate the services provided by each clinic, as this is the responsibility of the state licensing body.

There is also a Council of Psychoanalytic Psychotherapy in New York, which is a grouping of non-medical training institutes and clinics. The Council does not have any regulatory or licensing power. It attempts rather to provide guidelines for the work of the training institutes and clinics that have developed in New York exclusive of the medical schools and hospitals under the control of the medical profession.

Private practice in clinical psychology, then, can follow at least two patterns: 1) the psychologist can work alone in his own office and in collaboration with doctors in private practice, who refer patients to him and provide medical examinations for clients when needed; 2) the psychologist can work in a group practice or in a private clinic which has psychiatric and medical consultants, or which has psychiatrists directly involved as full-time staff members of the clinic. It has been found in the U.S. centres that the difficulty of achieving the first pattern has been in part, but only in part, responsible for the movement towards the second pattern. The basic reason for the difficulty has been lack of cooperation from doctors.

At present private practice in psychology is of negligible significance in Ontario. Whether it develops — and if it develops, what pattern it will follow — will depend largely on the extent of medical cooperation, the quality of training available for clinical psychologists, the public confidence they can establish by providing high quality services, and insurability under prepaid schemes such as OMSIP.

Education and Training for Clinical Psychologists

Clinical psychologists and psychometrists receive their training through post-graduate psychology departments in the graduate schools of the universities in Ontario. Clinical psychologists are trained in programs leading to the Ph.D. degree. Psychometrists receive a specialized training at the M.A. level.

The medical profession tends to be skeptical of the value of the training background of psychologists, particularly with respect to treatment skills. Their skepticism is not unfounded. Training programs in clinical psychology in Ontario are still rather rudimentary. Most of the programs emphasize experimental and behavioural psychology and research, and students obtain relatively little clinical background. This observation is confirmed by a consideration of the various programs offered by graduate schools in Ontario universities.

Carleton University

Carleton offers M.A. and Ph.D. programs in general experimental psychology only. There is no clinical or other applied program available. Degree requirements include practical training, but only in teaching or in research.

McMaster University

None of the courses offered is clinical in nature, in the M.A. or the Ph.D. programs. The emphasis is on research. The Department of Psychology has well-equipped laboratories for experimentation in learning, motivation, physiological and comparative psychology, and in animal research.

Queen's University

Queen's has separate programs in experimental psychology and clinical psychology, and a mixed program which combines the different courses for both M.A. and Ph.D. students. Clinical psychology is a four-year program; the M.A. degree is awarded at the end of the first calendar year, a Diploma in Psychology is awarded after the completion of the second year of Ph.D. work, and intensive supervision is provided throughout summer internships. Queen's University is preparing for the accreditation of its clinical program by the American Psychological Association.

The University of Western Ontario

Western provides training in general psychology with specialization in a dozen areas, including clinical psychology. The department offers adequate laboratory and other research facilities, and has potential field settings and sources of subjects in industrial and school settings, in hospitals and clinics. Practical work in approved settings is compulsory for students in clinical psychology, but there are practically no clinical courses. The stated primary purpose of the doctoral program is "to train scientists and university teachers".

The University of Windsor

A few courses are offered which are clinical in nature in the Ph.D. program, which also includes an internship of supervised clinical work in counselling and psychotherapy.

The University of Toronto

Toronto stresses training in general psychology with specialization according to the student's choice. In all areas of psychology the emphasis is on training for experimental research. There is little emphasis on clinical psychology, and there does not seem to be any compulsory internship in either the M.A. or the Ph.D. program. In general, the department takes little interest in clinical psychology. Its work is devoted almost entirely to behavioural research.

The University of Ottawa

Through the Faculty of Psychology and Education, the university offers degrees in clinical psychology at the M.A. and Ph.D. levels. The programs have been designed to meet the specifications of the Corporation of Psychologists of the Province of Quebec, the Ontario Psychological Association, and the American Board of Examiners in Professional Psychology.

Practica are available for students in the Psychology Guidance Centre operated by the faculty and in a local hospital. Students may specialize in guidance and counselling, or in clinical psychology.

The University of Waterloo

A research-applied oriented course is offered leading to the Ph.D., and an applied course leading to the Master of Applied Science degree. A specialized terminal Master of Applied Science degree program provides training for psychometrists.

The Ph.D. program offers a number of major areas of specialization, including clinical psychology and counselling psychology. These follow the model devised at the U.S. Boulder Conference (that is, the scientist-professional model). Faculty members feel that, given support, time and the requisite practicum settings, they will be able to build a program of excellent standard. A one-year internship is required. Supervision and the use of control cases is part of the practical training in diagnosis and therapy.

The department is applying for accreditation by the American Psychological Association, which would give their graduates access to clinics and mental health centres in the U.S.

University of Guelph

The department of psychology is only two years old and is still in the early planning and development stage. It proposes a full-scale program in clinical

psychology with a special emphasis on the study, diagnosis and treatment of behaviour disturbances in children. The University of Guelph has also created a Centre for Educational Disabilities which, in addition to its research activities, will undertake to train a number of different categories of professionals, from teachers of special classes in a certificate program to Ph.D. psychologists.

The departments of psychology at four of Ontario's major universities (Toronto, McMaster, Carleton and Western Ontario) are contributing nothing to the training of clinical psychologists. Among the older universities, Queen's and Ottawa alone have a Ph.D. program in clinical psychology. Among the new universities Waterloo, York and Windsor are making efforts to develop adequate programs. It is evident that when measured against the needs of mental health services in the province, the university departments of psychology are exceedingly inadequate on a number of counts. Their orientation towards, and preoccupation with, experimentation for its own sake make much of their work irrelevant. The clinical programs that do exist will not be able to provide the numbers of high quality clinicians needed. By and large, psychology has retreated into an ivory tower where it can pursue its own image of scientific purity without the disturbing intrusions of human problems and needs.

York University

York is currently undertaking the development of a Ph.D. program in clinical psychology and has recently undertaken an arrangement with the Ontario Hospital at Whitby, which will serve as a practicum setting for students.

Status of Clinical Psychology in Universities

Ontario now has two rather distinct groups of psychologists. On the one hand there is a scientific group, comparable to physiologists and biologists, located for the most part in university departments; and on the other hand, there is a professional group, comparable to physicians and engineers. The university psychologists are eager to win scientific respectability for psychology by the thorough-going application of scientific methods of observation and mathematical analysis to research in the field, and by the association of psychology with physiology and biology. For example, the University of Toronto Department of Psychology has decided to be classified within the Faculty of Arts and Science with botany and zoology as one of the life sciences, rather than with history, philosophy and economics as one of the humanities and social sciences.

This development has had a positive and a negative result as far as clinical psychology is concerned. Positively, it has provided the theoretical base for the development of behaviour therapy. Based on the same models of behaviour as experimental psychology and developing from learning theory, this therapy has been used for the treatment of certain behaviour disorders such as alcoholic addiction, fetishism, sexual deviation, and neurotic disorders involving phobia.

Negatively, this development has provided the theoretical justification for the failure of most psychology departments to develop any adequate curriculum in the theory and practice of psychotherapy and the diagnostic skills relative to it. Consequently, psychodynamic psychology (the psychology of unconscious, instinctual processes) has been developed almost entirely, in Ontario universities, by departments of psychiatry and, outside the universities, by psychoanalysts.

Even the positive consequences of the dominance of behavioural psychology in university departments are a mixed blessing for clinical psychologists in mental health services. Some psychiatrists are sympathetic to behaviour therapy, but others are not. V. J. Butler has commented enthusiastically on the effectiveness of behaviour therapy administered by a clinical psychologist within a group practice in an inpatient service. "It must be admitted that one has rarely seen impotency or phobias or compulsive rituals resolved so promptly, or sexual objects shifted so quickly."⁷ Other psychiatrists are skeptical to the point of indifference to the claims of behaviour therapy, on the grounds that it can, at best, bring about only a reorganization of the symptoms of the disorder. Any merits that behaviour therapy may have are likely to be offset by its adverse effects on clinical psychology. Certainly clinical psychology in Ontario has failed to keep pace with developments in the U.S.

In short, there exists within psychology itself a theoretical and professional barrier to the development of psychodynamic psychology, similar to the one in psychiatry examined earlier. Just as some psychiatrists have postulated a purely organic casual model for psychopathology and have hoped that by developing successful, exclusively physiological treatment methods psychiatry could best achieve full status as a highly respected specialty within medicine, so some psychologists have postulated a purely behavioural model for psychopathology and have hoped that, by developing exclusively conditioning treatment techniques, psychology could best achieve full status as a highly respected natural science. The psychiatrists and psychologists who are theoretically committed to these approaches tend to repudiate psychoanalysis and psychodynamic psychology as speculation, mythology and quackery. In any case, clinical psychologists who have seen the importance of a psychodynamic orientation in mental health, and have sought to qualify themselves as psychotherapists, have had to overcome the double disadvantages of interdisciplinary and intradisciplinary opposition. Consequently, relatively few clinical psychologists are qualified to practise psychotherapy. (Almost all of these psychologists have trained in the U.S. or have trained informally in Ontario in *ad hoc* in-service programs developed by sympathetic psychiatrists.) This training defect provides de facto justification for the psychiatrists who want to exclude psychologists from the practice of psychotherapy.

⁷V. J. Butler, "Collaboration between Psychologists and Psychiatrists in Psychotherapy", *Canadian Psychiatric Association Journal*, Vol. 12, No. 1, p. 68.

Clinical psychologists often find themselves in a vicious circle. Because psychiatry and medicine have dominated mental health services, psychologists have tended to withdraw from these services. Consequently, graduate education in psychology has mobilized almost all of its resources in the direction of scientific, experimental research and in applied fields such as educational psychology, which are not directly involved in the diagnosis and treatment of psychiatric disorders. Thus training in clinical psychology, by and large, has failed to keep pace with improvements in psychiatric training; and psychiatrists are justified in the view that, for the most part, they are the best qualified members of the mental health professions and should retain responsibility for the diagnosis and treatment of patients.

Although this is an accurate enough general description, individual universities, such as Queen's, Waterloo and York, have been working against the tide. Queen's and Waterloo are of particular interest, because they are both moving towards an application for accreditation by the American Psychological Association. More will be said on this point in a moment.

Status of Clinical Psychology in Mental Health Services

A number of psychiatrists interviewed who were sympathetic to the potential of clinical psychology unequivocally denounced the existing authority and responsibility structure in mental health which places medicine inevitably at the top. They felt that psychiatry was entirely responsible for the current shortage of able clinical psychologists in nearly every service.

This quality of the relationship between medicine and psychology was pointed out by a psychiatrist in one of the province's leading psychiatric hospitals. He said that the hospital is unable to retain its best clinical psychologists because they are highly trained professional people, and no self-respecting professional will work under the conditions of subservience to medical authority and control to which they are typically and unreasonably subjected. The same factor was cited by a leading psychology professor, who stated that the basic reason for the lack of sufficient numbers of Ph.D. psychologists in mental health services has been the failure over the past twenty years of the persons who have been in charge of these services to attach any appropriate value to the services of qualified psychologists. Instead of taking the necessary steps to support sound training programs and create the positions through which such trained professionals could provide high quality service, the mental health services of Ontario have encouraged the employment of untrained or semi-trained personnel in psychology. Thus they have forced the most capable to leave clinical services for work with schools and other agencies, where salaries and conditions of employment are commensurate with the professional skills and stature of the Ph.D. psychologist.

Although the reality of the mental health problems and the rhetoric of the mental health team support interprofessional cooperation based on equality, medicine and psychology are in a state of cold war in the field of mental health. As an indication, clinical psychologists are proud, but surprised, if one of their profession manages to become responsible for the treatment program in the ward of a mental hospital; but usually the feeling is that it cannot last long. Another indication is the feeling among some psychiatrists who have actively supported and trained psychologists to become psychology psychotherapists — that is, “counsellors” — that they are somehow betraying their own profession.

The status of clinical psychology in the universities, combined with its status in the mental health services, presents a major dilemma for many psychologists.

The Dilemma of Clinical Psychology

This dilemma is implicit in the description of professional psychologists adopted as an ideal by the Couchiching Conference.

The professional psychologist has broad interests in those areas of applied psychology within his field of competence. He plays an active role as a supervisor, co-ordinator, advisor, and consultant to other professions and to management. He approaches these activities with a research orientation that differentiates him from other professionals. Time demands limit his personal efforts to diagnose causes of individual maladjustment and to induce behaviour changes, but he accepts responsibility to train and supervise technicians to relieve him of many repetitive tasks. In all likelihood, he will seek a university appointment through which he can assist in the training of students.

To undertake such activities the professional psychologist requires a doctorate degree — preferably a Ph.D. obtained at the end of a programme based on the scientist-professional model. He must be well trained and competent in applied research. His training must provide him with current technical know-how in his area of specialization, but more important, it must give him a sound understanding of appropriate psychological theory and principles. His background in general psychology must be such that he will be an acceptable peer of other psychologists holding major academic appointments.⁸

To the outside observer this prescription for the ideal clinical psychologist has, apart from the usual professional truisms, two outstanding features. It provides a covering rationalization for the defeat of clinical psychologists in any conflict with psychiatrists concerning their right and competence to undertake psychodiagnosis and psychotherapy, thus expressing a profoundly defeatist attitude which is the hallmark of every group that “knows its rightful place” in the order of things. The telling clause here is “Time demands limit his personal efforts to diagnose causes of individual maladjustment and to induce behaviour changes . . .” Literally thousands of clinical psychologists in the U.S. do not experience any such a priori limitations on themselves as a result of “time demands”. The U.S.

⁸*The Couchiching Conference on Professional Psychology, op. cit.*

Veterans Administration has trained 6,000 clinical psychologists and 1,500 counselling psychologists in its training program since it was inaugurated after the Second World War. These psychologists are trained under supervision in psychodiagnosis, psychotherapy, behaviour therapy, vocational counselling and research.⁹ There is no suggestion that they are not expected to be hired to do what they are trained to do, or that "other commitments" are expected to intervene in their psychodiagnostic and psychotherapeutic work and supersede it.

Like every other group that has preselected for itself a position of inferiority in the professional hierarchy, Ontario professional psychologists have preselected another group to be inferior to themselves. Although the psychologist is not to have much time for psychotherapeutic work, he will have time for and is even willing to accept "the responsibility to train and supervise technicians to relieve him of many repetitive tasks". Having thus found himself in a situation in which he has little that is worthwhile or challenging to do, and being debarred, not by time but by medicine, from becoming deeply involved in mental health work, "in all likelihood, he will seek a university appointment through which he can assist in the training of students". It is well that the word "seek" is used, because the word "find" would be inappropriate. Most university departments, finding that medicine has taken possession of the responsible and professionally rewarding work in mental health services, have simply withdrawn their interest from it and are unprepared to encourage capable students with an interest in and aptitude for advanced work in psychology to enter a field that will be unrewarding professionally. Seen from this point of view, the Couchiching prescription for an ideal professional psychologist is the prescription for an "ideal mental hospital, Department of Health employee, psychologist". The two should not be confused.

The second striking feature of the Couchiching prescription is the demand that the clinical psychologist be "well trained and competent in applied research" and "be an acceptable peer of other psychologists holding major academic appointments". These elements define the major components of the scientist-professional model. But it is a model that is rather impractical, if taken seriously. If a psychologist is to be well trained in research and also in psychodiagnosis and psychotherapy, his training after the M.A. could take no less than eight years and might well take up to twelve years. If, in addition, the clinical psychologist is to remain an acceptable peer of psychologists holding major university appointments, he will have to earn this acceptance by doing the amount and quality of research that they do and, in some cases, there would be the additional requirement that the same methods and models also be utilized.

A Way Out of the Dilemma

A group of psychologists at Harvard University have faced this problem squarely

⁹Personal communication, H. M. Engle, M.D., Chief Medical Director, Veterans Administration, Department of Medicine and Surgery, Washington, D.C., November 30, 1967.

during the last two years. In essence, the terms of the problem as they see it are these. First, there is a grave need for university-trained psychological diagnosticians and therapists to man the community mental hygiene clinics currently under development. Second, the university department of psychology does not have the ability to train them because 1) although they are needed as university teachers, senior clinicians cannot receive university appointments in psychology, because they do not have sufficient publications; and 2) the Ph.D. in psychology is a research degree, whereas what is needed is a service degree in which the clinical practicum takes the place of thesis research. The solution preferred by the team of psychologists who studied the problem was the formation of an interdepartmental program, headed by a professor with clinical and not necessarily research qualifications to supervise a service-oriented training program resulting in a doctorate rather than a Ph.D. The program would require the same quality of achievement and promise in diagnosis and therapy (mental health services) that is now required of Ph.D. candidates in research; it would replace the research thesis with a thorough practicum.

Only with such training can clinical psychologists be expected to thrive. Whether they like to admit it or not, they are in a service profession which overlaps with medicine in certain areas; and medicine is a profession in which service has always been of first importance. Therefore, in order to secure the full cooperation of medicine and a sharing of responsibility and work in the area of overlap between the professions, psychology must demonstrate its ability to provide diagnostic and therapeutic services of equal merit. And if in addition clinical psychologists who have devoted themselves entirely to clinical work are to command the full acceptance of their peers in major academic appointments, then major academic posts will have to become available to psychologists who are first and foremost accomplished clinicians.

There is, of course, another alternative. The current situation could be preserved and clinical psychologists could continue to exist as an ancillary profession to medicine in mental health, providing certain limited technical services through the routine administration of standard tests. And clinical psychologists could continue to attempt to satisfy the contradictory ideals analyzed above and console themselves, whenever they found that they could not, that they were professionally superior to the psychometrists who really are only psychological technicians. Against this alternative there is a decisive argument based on public interest. The people of Ontario need more high quality psychodiagnostic and psychotherapeutic services than can be provided by medicine or by psychology as it is presently functioning. This fact becomes evident when manpower in psychology is considered.

The Shortage of Psychologists

Many surveys have been made regarding manpower supply of and demand for psychologists. Two surveys have been made recently: one is by the Ontario

Psychological Association, "Manpower Needs in Psychological Services in Ontario, 1965-1970";¹⁰ and the other is by M. H. Appley and Jean Rickwood, of York University, on psychologists across Canada in 1967.¹¹ The former report estimates that during the period 1965-1970, universities of Ontario will produce about 900 graduates at the Master's level, of whom about half will continue with graduate work. About 400 Ph.D.'s will graduate, but more than 150 of these can be accommodated by vacancies to be created in Ontario universities within the same period. Another ninety-odd Ph.D.'s will be absorbed into burgeoning university and college departments across the country, while an estimated sixty-six will go into research. Less than a hundred will be left to be distributed among the various applied psychology settings in the province. These estimations have already taken into consideration the expansion of existing university faculties and the addition of graduates who will be granted Ph.D.'s by newly established or to-be-established Ph.D. programs at Carleton, Windsor and York Universities, and at the Ontario Institute for Studies in Education (OISE).

Another factor which also has to be considered in estimating manpower supply is that an allowance must be made for "brain drain", especially to the U.S. According to the survey by M. H. Appley and Jean Rickwood, an estimated total of approximately 160 U.S. citizens are now working as psychologists in Canada, while about 240 Canadians are employed in the U.S. The survey concludes that more Canadians are "lost" to the U.S. than Americans are "gained" by Canada.

Meanwhile, on the demand side of the manpower situation, one hears of critical shortages from every applied setting in the province. A survey conducted by Raymond Berry of the Department of Health shows sixty-five listed vacancies for psychologists in existing services in institutions operated by the Department of Health.¹² That is to say, there are sixty-five *unfilled* positions; these do not include the additional positions that would be created by any expansion of services or by an improvement in staff-patient ratios, both of which are needed. This means that if more psychologists were available, more positions would be covered in the budget to satisfy staff requirements. In the Brief to the Committee on the Healing Arts submitted by the Ontario Psychological Association, the Ontario Board of Examiners and the Canadian Psychological Association, it was said that more than 100 qualified clinical psychologists are needed to meet *minimum* requirements for staff in health agencies in operation or in process of development; and a similar number are needed in school systems.

¹⁰Report of the Committee on Professional Affairs, *Manpower Needs in Psychological Services in Ontario, 1965-1970*, OPA Quarterly, Vol. XVIII, No. 2, Summer 1965.

¹¹M. H. Appley and J. Rickwood, *Canada's Psychologists*, York University, prepared for the Scientific Secretariat (Privy Council) of Canada, in behalf of the Committee on Research Financing of the Canadian Psychological Association, 1967.

¹²Survey by R. G. Berry, Advisor in Psychology, Professional Services Branch, Mental Health Division, Ontario Department of Health, 1967-1968.

Larger numbers are required if overall community demands for clinical services are to be met, not to mention demands from such quarters as industry, counselling and the Armed Forces.

In the light of the estimates of the Ontario Psychological Association Committee on Professional Affairs, existing training programs at best will provide for one-half of the estimated need.

Various solutions to this manpower problem have been proposed. These include better use of existing Ph.D. personnel; a wider use and recognition of those with M.A. and B.A. training in psychology; an increase in the availability of training facilities and staff; and an increase in financial support, in the form of grants, to attract well-qualified students to psychology programs.

The problem of expanding training facilities both in universities and practicum settings in teaching hospitals and clinics is crucial; for without expansion here, Ontario will never be able to supply its own needs for clinical psychologists. At the same time, there must be assurances that there will be enough students to fill these expanded facilities. In 1967 a survey was conducted to determine whether training programs in Ontario were operating at capacity.¹³ The survey included nine departments of psychology in Ontario universities which provide graduate training, located at Carleton, McMaster, Ottawa, Queen's, Toronto, Western Ontario, Windsor, and York Universities, and at the Ontario Institute for Studies in Education. These schools had a total of 1,421 completed applications to their graduate programs, of which only 347 people were taken into graduate training: 103 at the Ph.D. level, and 244 at the M.A. level. Although the 1,421 figure undoubtedly contains both duplicated applications (and it is impossible to know how many duplications there were) and applications from unqualified students, the number of qualified applications probably greatly exceeded the number of applications accepted. An increase in the availability of facilities and staff almost certainly would increase the number of students in training in universities in Ontario. We note, however, that this finding does not reduce the need for encouraging and attracting more well-qualified students into the field by improving the quality of existing programs.

Another source of manpower supply is the recruitment of psychologists trained outside Ontario. The obvious first choice for recruitment is the United States. At once the problem of salary arises. University departments usually can offer a maximum of \$13,000-\$15,000. Clinics and hospitals are unlikely to be able to offer much more; and even if they could, they would not be competitive with similar American institutions in terms of both salary and working conditions. American clinical psychologists who have come to Canada to take up university appointments have suggested that Ontario could compete in the market for

¹³*Ibid.*

American clinical psychologists by offering cross-appointments to psychology departments in clinics or hospitals, and to psychology departments in universities. Such appointments would be attractive, in terms of the work opportunities offered, to clinical psychologists of high calibre who want to be able to combine clinical work, teaching and research but who find some difficulty in doing so in the U.S. It is psychologists with these capabilities and interests that Ontario now most needs.

In addition to the need for Ph.D. psychologists, there is a need for more M.A. psychologists to undertake routine diagnostic work in psychological services and to contribute generally to the planning of treatment programs.

The M.A.Sc. program at the University of Waterloo, said to be the first of its kind in Canada, is a very recent experiment in training such psychologists. The course started in 1966 with a class of fourteen students. It is a terminal Master's course, requiring two years after an honours B.A. degree. The program consists of two terms of field work and three terms of academic work. Each term is of four months' duration, the academic alternating with the practicum. Courses are offered in personnel and industrial psychology, educational psychology, and counselling and rehabilitation, with an emphasis on testing theories and on practical work. The M.A.Sc. is a service rather than a research degree.

The agencies where the students do their field work are first contacted by the Coordination Department of the University. The students then interview each of the agencies that would be suitable for their field of specialization and rank them according to their own choice. The agencies also rank the students interviewed. These choices are then matched, and top priority is given to the resulting preference shown. The student is supposed to receive close supervision during his internship, but the amount of supervision received depends on the agency. The details of the internship program also are not explicitly outlined and the experience which the trainee gets depends very much on the situation in the agency. One of the practicum settings for students in this course is the Neuropsychiatric Clinic operated by the Department of Reform Institutions at Guelph. The Director of Psychology was extremely satisfied with the training of students he was receiving and with the contributions that they could make, when trained, to his service. At the Neuropsychiatric Clinic, essentially a diagnostic centre for inmates of Ontario's reform institutions, the limitation of the M.A.Sc. to diagnostic work is an asset rather than a liability, since it is experienced diagnosticians that are needed. Treatment is provided elsewhere (if at all).

Students in this program expect that they will have an advantage over those who graduate from the M.A. course, since they have a stronger applied background and should not have to spend so much time in on-the-job training when they are employed in service settings. The class which enrolled in 1967 has twenty students, and the department intends to expand the course to a size of

forty-five to sixty. There is one problem, however, which has to be solved: the status which is to be accorded to graduates of this and similar programs in terms of registration and legal recognition.

The strategy behind this program for solving part of the manpower problem contains four elements: 1) identify a specific set of social and individual needs; 2) identify a corresponding specific set of services that can be performed on the basis of M.A. level preparation; 3) split these services off from the total range of expertise of the Ph.D. psychologist and form them into a limited set of skills (in this case largely diagnostic); 4) design a training program with a strong practical orientation to train persons in the expertise in question. Since there is a need for psychometrists, the program works well.

There is an obvious need for the application of a somewhat similar strategy for Ph.D. psychologists who will be eligible for registration.

Suggested Improvements in Postgraduate Programs

In May 1965, a conference was organized by the Canadian Psychological Association Committee on Professional Problems to define professional psychology and to clarify the objectives of professional training. Four training models were presented during the conference. These models, which represent the major alternatives for graduate training in professional psychology in Canada today, can be summarized as follows:

- 1) *A professional and an academic degree offered in the same department of psychology.*¹⁴ According to this proposal, there will be two distinct types of doctorate offered by the same department. Training at the undergraduate level is common to all candidates; at the graduate level, there will be two different courses, with certain common elements, especially during the first year. One is the academic course for research and teaching, and the other is the professional course with areas of specialization (clinical, industrial, educational and others). Both will be four-year courses leading to a Ph.D. degree. The professional course will include a year of internship at the third or fourth year of the course.
- 2) *One doctoral program leading to the Ph.D. in a department of psychology.*¹⁵ This proposal provides for one undifferentiated graduate program in psychology. A person who has had a general liberal arts education of three years would take three more years to work for his Ph.D. in research, but this training would not be intended to prepare him for his life work. The psychologist would have to

¹⁴*The Couchiching Conference on Professional Psychology*, Position Paper I by R. P. Adrien Pinard, *op. cit.*

¹⁵*The Couchiching Conference on Professional Psychology*, Position Paper II by C. Roger Myers, *op. cit.*

take another three years of postdoctoral specialized professional training, depending on his choice of a career in research and teaching or in clinical, educational or industrial psychology.

- 3) *Graduate professional training in psychology in a department other than psychology.*¹⁶ This proposal is favoured by many people, because a separated department in the Faculty of Graduate Studies would have much more freedom in matters of staff appointments, curricula and standards. A graduate of such a program should be awarded a degree other than a Ph.D. — for example, a Doctor in Applied Psychology or some equivalent doctoral title.
- 4) *An updating of the presently approved American psychological program to produce scientist-professionals.*¹⁷ This model, endorsed since the Boulder Conference of 1949, is still accepted by most universities. It envisages the psychologist as one who will be prepared to do research even though his primary function is that of service; one who will be able to contribute through research and scholarship to the development of the techniques and methods of the profession; one who can choose sound procedures and reject worthless ones, because he can react critically to the evidence behind new theories and methods. Unfortunately, relatively few graduates have been produced who approach the objectives of this model. When the graduate goes out into the service setting, he finds that he is ill-equipped to deal with the situations presented, because his training has been too academically oriented. As a result, a large number of graduates give up their clinical work in disappointment to return to a teaching position in universities.

Of the four proposals only one — the third, or graduate professional training in psychology in a department other than psychology — will resolve the dilemma in which clinical psychologists find themselves. As already indicated, Harvard University has such a development under consideration. It is an approach that is strongly favoured by some leading American clinical psychologists. Since such a program would have advantages for professions other than psychology, a consideration of a detailed proposal will be left for the final chapter of this section. The initiation of such a program in a major Ontario university could be the most important single step towards the resolution of the manpower problem in mental health.

Training Standards and Accreditation

It generally is acknowledged by clinical psychologists that postgraduate training

¹⁶*The Couchiching Conference on Professional Psychology*, Position Paper III by P. Lyner Newbigging, *op. cit.*

¹⁷*The Couchiching Conference on Professional Psychology*, Position Paper IV by Virginia I. Douglas, *op. cit.*

programs need reinforcement and expansion (Tables 10.17, 10.18, and 10.19). Field interviews confirmed the questionnaire evaluations and supplied a set of specific criticisms.

Admission

In screening candidates for applied courses, too much emphasis is placed on a certain kind of academic achievement and interest. Consequently, the wrong kind of students sometimes are selected, students who may not have the personal qualities essential to the making of a good practitioner. These qualities include perception, empathy, psychological insight, realism and practical ability. This opinion, cited frequently in field interviews, was repeated in comments in the questionnaires. All those who were not satisfied with the present entrance requirements recommended that there should be better screening of candidates to psychology programs, so that only students with suitable personality traits would be admitted.

Orientation of Curriculum

The present programs have a heavy academic bias and are inadequate in applied psychology. The graduate has had little training and experience in dealing with people and handling actual situations. He is unable to recognize symptoms in behaviour disorders when he graduates and becomes dependent on in-service training programs for developing his professional clinical capabilities for treating patients.

Overemphasis of Research Skills

Ph.D. programs in psychology tend to be dominated by highly sophisticated research methods which students must master. These methods are essential for advanced research and are useful for the experimental psychologist, but they are not basic to the training needs of clinical psychologists.

Absence of Human Element

Students should be trained to be more aware of people and their problems. At the same time their training should lead to an increasing awareness of their own psychodynamics.

Lack of Contact with Other Professionals

The students are not given any knowledge of the work of other professions with whom they are going to work when they go into practice. This ignorance frequently results in unsuccessful communication and collaboration with social workers, psychiatrists and medical practitioners in future work settings. Psychologists do not have any idea what a multidiscipline team is like and therefore experience difficulty in defining their own role in the team.

Inadequate Internship Programs

There is a lack of adequate internship programs. Many training courses do not include an internship program at all, and those that do are mainly of the on-the-job-experience type without structure and consistency. The student receives little supervision and the tie between the placement agency and the university is usually a very loose one.

These are serious criticisms. As we have seen, they are the cause of a considerable and highly undesirable lack of confidence in the training of clinical psychologists among psychiatrists (Table 4.15). If psychology is to secure the full cooperation of psychiatry, then it must secure its confidence.

It will be of great benefit to clinical psychologists in the improvement of the standard and status of their profession if the Canadian Psychological Association were established as an accrediting body for graduate programs in clinical psychology in Canada with reciprocity with the American Psychological Association. Because clinical psychology in Canada is still not as advanced as it is in the U.S., nor as advanced as experimental psychology in Canada, the Canadian Psychological Association has done little to date to establish machinery for this purpose. As a result Queen's and Waterloo have applied directly for accreditation to the American Psychological Association. This represents an important step towards continental integration at the professional level, following upon progressive integration at the economic level. This integration already exists in social work training.

The Ontario Psychological Association has appointed a Board of Education and Training for the purpose of establishing standards for applied training, advising on the establishment of applied programs, assisting fund-granting bodies in identifying appropriate programs, and preparing guidelines for evaluating and accrediting graduate programs in applied fields of psychology. The results of the Board have been published in a report,¹⁸ outlining the machinery involved, the procedures for accreditation of programs, and the standards for training programs in applied psychology. The latter include standards for general program characteristics; selection and retention of students; content of undergraduate instruction; content of graduate instruction; practicum training; staff; facilities; and overall atmosphere.

Steps have been taken to have these accreditation procedures adopted and implemented by the Board of Education and Training under the auspices of the OPA Board of Directors.

It is not known how many university departments of psychology have applied

¹⁸OPA Training Board, Report to the Board of Directors on Standards for Training Programmes in Psychology, *OPA Quarterly*, Vol. XX, No. 1, 1967.

for accreditation, but field interviews indicate that not much attention has been paid to this accrediting body. In contrast, great importance is attached to recognition by the American Psychological Association. It would appear, then, that the best course of action is one in which the Canadian Psychological Association establishes an accrediting board to guarantee a national standard and, through cooperation with the American Psychological Association, to ensure that the Canadian standard is at least as good as the American.

The American Psychological Association establishes a number of criteria concerning curriculum and training standards which any Ph.D. program must meet in order to be accredited. Among these are the following: the department must have already graduated some Ph.D.'s as a guarantee that the program is well established; and the university department of clinical psychology must have a satisfactory relationship with a suitable mental health institution that provides practicum training. A satisfactory relationship is one in which the clinical psychologists in the practicum setting are not themselves members of the university department, so that they can appraise the trainees quite independently of departmental loyalties or interests. And a suitable practicum setting is one in which such experienced clinical psychologists are situated and in which trainees can receive the requisite practicum experience under their supervision or the supervision of an equally qualified psychiatrist. In Ontario, this is a relatively difficult requirement to meet. At present the University of Waterloo has available to it only three institutions that can qualify as practicum settings: the Training School at Galt (Department of Reform Institutions), Lakeshore Psychiatric Hospital, and the Ontario Hospital at Hamilton.

The practicum consists of three units: intelligence testing, personality testing, and psychotherapy. These units are taken in sequence over a three-year period. The third unit is of major interest to this report and deserves particular attention. Candidates are trained in psychotherapy in a staged program which involves an introduction to psychotherapy via audio and visual tapes, group sensitivity sessions, and the treatment of patients under supervision.

The American Psychological Association requirements have the obvious advantage that they demand the kind of practical orientation to clinical work and supervised clinical experience, both in diagnosis and treatment, that most clinical psychologists have singled out as the major weaknesses in their training. It will take time, effort and financial support if these demands are to be met for the nascent university programs in Ontario, because there is a serious shortage of highly trained senior clinical psychologists who qualify as practicum supervisors in Ontario's mental health services. There is evidence, moreover, of some reluctance on the part of government to give the support needed.

It has already been pointed out how objectionable to senior psychologists are the hiring policies of the Department of Health. These policies, if continued, will

maintain the currently unsatisfactory situation. One might argue in extenuation that properly trained clinical psychologists have not been available. But there is also evidence that requests for the financing of the expansion of established programs — such as the one at Queen's, which would add to the supply of well-trained Ph.D.'s in clinical psychology — have been rejected by government. York University's program also has encountered difficulties in securing long-term financing for expansion. Such financing is essential. Ontario needs to be able to import from the U.S. senior clinical psychologists with established reputations in order to make any kind of adequate progress over the next decade, and in order to do this money is needed to create attractive clinical and academic appointments on a long-term basis. It is essential that vigorous steps be taken to strengthen psychology in hospital and clinical services, so that high quality practicum settings are available. Otherwise, the important efforts of some university departments to create programs worthy of accreditation will be frustrated.

In achieving this objective, a second difficulty must be considered on the side of the universities. In Ontario universities are financed according to a formula established by the Department of University Affairs in consultation with them. The use of these funds is determined by the universities themselves. Thus at any given university the Department of Psychology will receive from the general university budget a certain amount for faculty expansion. But if the department is dominated by experimental psychologists, no appointments in clinical psychology will be made. Nothing can be done through formula financing to alter this situation that would not adversely affect the autonomy of the university and its departments. The Department of University Affairs, however, is in a position to finance new programs outside, above and beyond the allocation of formula funds. This developmental financing can be targeted for the establishment and expansion of clinical psychology training programs without interfering with general university administrative autonomy.

Two further aspects of the problem require comment. The criteria for the willingness of a psychology department to embark on a significant development in clinical psychology are its willingness to appoint brilliant, seasoned clinicians irrespective of their research publication to senior departmental positions, and its willingness to accept the clinical expertise of doctoral candidates acquired through practicum training as a valid substitute for research competence acquired through thesis research. Universities that do not satisfy these criteria will be able to contribute substantially to the growth of clinical psychology only through the establishment of independent interdepartmental and interfaculty programs. It is likely that some universities will be able to move forward only by means of the interfaculty program. This fact should not be considered disadvantageous. On the contrary, one of the criticisms of the current programs can be met by an interfaculty program — namely, the failure to provide shared training experience and close contact with the professions with whom psychologists must work in mental health services.

At present the university departments, and therefore the Canadian Psychological Association, are dominated by experimental psychologists. In order to provide the proper professional environment for the growth of clinical psychology, it may be necessary for a division of the Canadian Psychological Association, to which clinical psychologists would belong, to have responsibility for the work of the accrediting board through the exercise of responsibility for appointments to it.

Practice of Psychotherapy

If the policy for accrediting postgraduate training programs in clinical psychology is adopted, then clinical psychologists must be given the right to become trained psychotherapists, since common standards with the American Psychological Association would require it. The issue has already been considered in Chapter 4, but it is so important that it deserves reiteration here from the point of view of psychology.

The definition of psychotherapy adopted by the Canadian Psychiatric Association Board of Directors in 1964 is that

Psychotherapy is a medical act by which a physician through sessions of verbal or other communication explores and attempts to influence the behaviour of a psychiatrically disordered patient with the objective of reducing his disability.¹⁹

Calling psychotherapy a "medical act" excludes any profession other than medicine from qualification to provide it. Those who are in favour of this restriction believe that unsupervised psychotherapy by clinical psychologists is a potential danger to the patient. They think that the mentally disturbed patient, with a host of psychic and somatic symptoms, is as medically ill as a patient suffering from an organic disease. Any therapist who undertakes to treat him is practising medicine without training or licence. They point out also that the psychologist cannot take advantage of drugs as a therapeutic aid. A psychologist can, of course, make referrals to a physician. But this procedure (it is said) places the doctor in question in the position of prescribing for a patient whose psychodynamics are unfamiliar to him. Moreover, the treatment of the patient is fragmented. Even so, they doubt that the psychologist is qualified to know when medication and hospitalization are required by a patient, since he is not trained to recognize disease symptoms. Other forms of treatment (such as electroconvulsive therapy) also are not available to the psychologist. A psychologist could be trained to do psychotherapy under medical supervision, but he must be prevented from leaving the treatment team and going into private practice.

Other psychiatrists disagree with this position. It is reported that 39 per cent of the members of the Canadian Psychiatric Association opposed the adoption

¹⁹Principles underlying Interdisciplinary Relations Between the Professions of Psychiatry and Psychology. A position statement by the Council of the American Psychiatric Association, February 1964.

of the definition of psychotherapy cited above, because they believe that colleagues in psychology have had special training in psychotherapy and should, therefore, be recognized practitioners of it. The term "psychotherapy" is included in most job descriptions of psychologists, including psychologists employed by the Ontario Department of Health and the Department of Reform Institutions. In order to find out whether psychiatrists by virtue of their training are better qualified to do psychotherapy, one psychiatrist made a list of all the courses of his premedical and medical education for the purpose of assessing their relevance to his functioning as a psychotherapist. He concluded that psychiatrists do not have any significant advantage over clinical psychologists, social workers and non-medical psychoanalysts in giving therapy.²⁰ He said that virtually all his internship and medical school experience, with the single exception of the specifically psychiatric courses and clerkship, was irrelevant. Premedical courses also were grossly irrelevant, with the exception of courses in English and philosophy. He pointed out that very few psychiatrists perform physical examinations except on hospitalized patients, and then only in compliance with hospital rules. As for the prescription of drugs, this is usually limited to psychiatrists in hospital situations. Moreover, "all the factual material relevant for the effective and practical use of the psychoactive drugs could be learned in two weeks by the average intelligent student in the mental health field". Most psychologists would agree with this and with his definition of the mental health field:

That area of human endeavour devoted to helping persons with emotional or psychological problems; it is the field of man's anxieties, depressions, irrational doubts and fears, irresponsibilities, disturbed social relations, maladaptive behaviour, disturbed thinking—the field of the psychic problems of man as man, a social, symbolizing being, not as a biological machine.²¹

He concludes that for the mental health profession, psychology (or more generally, "behavioural science") is the basic academic discipline, plus some knowledge of sociology, human biology, and a broad humanistic education and training in scientific methods. Workers in the mental health field should be trained in a school of mental health, studying the existing curriculum in clinical psychology (in the U.S.) and including appropriate additions from other fields (medicine, sociology, social work).

Thus a major issue inherent in the accreditation of Ontario's university departments of clinical psychology is the question as to whether or not psychotherapy is properly described as a medical act to be performed only by physicians. The American Psychological Association clearly will not accept this assumption, nor will it accredit any school that premises its training of clinical psychologists on it.

Clinical psychologists in the U.S. have worked out two principal lines of

²⁰Allen S. Mariner, "A Critical Look at Professional Education In the Mental Health Field", *American Psychologist*, Vol. 22, 1967, pp. 271-281.

²¹*Ibid.*

defence for their right to practise and teach psychotherapy. The first line of defence, as already indicated, is the American Psychological Association. This Association accredits hospitals and clinics as teaching institutions for internes in clinical psychology for the Ph.D. It requires of any clinic or hospital, before it may be accredited, that it provide at least two of three basic training components for its Ph.D. internes: these are diagnosis, therapy and research. It is mandatory, however, that the training policy of any such clinic or hospital accept in principle the training of clinical psychologists in psychotherapy and the teaching of psychotherapy by clinical psychologists. A clinic may not, in fact, be equipped to provide such training and is acceptable as long as its training policy does not exclude it.

The second line of defence is the university departments themselves. No university department will permit a Ph.D. candidate to take any part of his internship in any institution that rejects the teaching of psychotherapy by clinical psychologists to candidates in clinical psychology. For example, New York City's Mount Sinai Hospital adopts the policy that clinical psychologists should not dispense psychotherapy, nor should they teach it. Consequently, Columbia University, which has an excellent graduate program in clinical psychology, will not permit any Ph.D. candidates in clinical psychology to do any of their internship in the hospital.

A third potential line of defence for the right of clinical psychologists to practise psychotherapy is state certification and licensing laws. The State of New York has such a law, although its interpretation is still the subject of dispute. The New York State Psychological Association, which favours the licensing of psychologists, takes the view that the existing law does license clinical psychologists in private practice to do psychotherapy.

In conclusion, there appears to be no sound reason why a clinical psychologist properly trained in psychodynamics should not practise psychodiagnosis and psychotherapy in a public service or private practice, subject only to the limitation prescribed by psychoanalysis for psychoanalysts without medical training: that they treat patients only on referral from physicians. The majority opinion of psychologists on this question (Table 10.22) should be accepted.

Registration and Licensing

Professional psychology is governed at the present time by the Psychologists Registration Act, 1960. The Act has some general and specific inadequacies, which have come under criticism by psychologists officially through the Brief of the Ontario Psychological Association to the Committee on the Healing Arts, and unofficially through field interviews for this report.

The main objections are to Sections 11 and 12. These objections may be listed as follows:

- 1) The Act was designed primarily to protect members of the public from incompetent persons and charlatans. It does not serve this purpose adequately, since Section 11 places the restriction only on an unregistered person who:

By any title, designation or description incorporating the words "psychological" "psychologist" or "psychology" and under such title, designation or description offers to render or renders services of any kind to one or more persons for a fee or other remuneration.

An unregistered person could, therefore, give any of the services a registered psychologist gives as long as he does not use the words "psychological", "psychologist" and "psychology". He could advertise himself as a marriage counsellor, as a specialist in human relations and family counselling, as a consultant in personal and social problems, as a public relations counsellor, as a psychosomologist or even, as things now stand, as a psychoanalyst.

- 2) Included by the psychologists among those who are unqualified to provide psychological services are the medical personnel who are specifically exempted from the restriction of the Act. Section 11 states that

This section does not apply to a duly qualified medical practitioner

Psychologists are justly bitter about this arbitrary exclusion of doctors from the requirement of being trained. They say that this provision is as ridiculous as exempting psychologists from the Medical Act. They emphasize that medical practitioners do not have any training at all in the use of behaviour modification techniques and procedures for the assessment of individual mental functioning. While the medical profession attacks the psychologists for their lack of medical training, psychologists counter by taking the position that physicians have little or no knowledge of maladaptive behaviour or its diagnosis and treatment, and should not be allowed to work in this area without collaboration with psychologists. Therefore psychologists are of the opinion that this section of the Act should be repealed.

- 3) The third objection is to Section 12 of the Act which states that:

No person who holds a certificate of registration shall treat any person for any type of mental disorder for a fee or other remuneration except on the request of or in association with a duly qualified medical practitioner.

As the OPA's Submission to the Committee points out, this section places a vague restriction on the work of *registered psychologists*, a restriction which applies to *no one else*. Like Section 11, it fails in its purpose of protecting the public from unregistered persons.

The rationale for the regulation is the need to avoid the danger to a patient of an undiagnosed physical illness concomitant with,

contributing to, or the single cause of psychological symptoms. But the clause is discriminatory and inconsistent when seen in relation to Section 11. For there is an opposite and equal danger that psychopathology will go undetected and untreated, if physicians with no training in psychiatry and psychology are allowed to treat psychiatric cases without consultation with a psychiatrist or a psychologist.

The removal of this inconsistency requires an unequivocal affirmation of the principle that professional competence should depend on expertise, and expertise depends on training. This principle requires that clinical psychologists should work in association with physicians, and that physicians, without psychiatric, psychoanalytic, or psychological training, should work in association with clinical psychologists, psychiatrists or psychoanalysts in the diagnosis and treatment of psychological disorders. Legal responsibility should be based on professional expertise: doctors being vested with responsibility for medical contributions; clinical psychologists, psychiatrists and psychoanalysts being vested with responsibility for psychological, psychiatric and psychoanalytic contributions.

Psychologists already are committed by their code of ethics to the principle of collaboration with physicians.²² Consequently, there should be no basic objection to the legal requirement of collaboration, as long as it is reciprocal. But no one should be so naive as to think that psychologists will not continue to experience difficulties in their collaboration with doctors, even after the defects in their training programs are removed.

It would appear reasonable to adopt the recommendations of the Ontario Psychology Association, Ontario Board of Examiners in Psychology, and the Canadian Psychological Association to amend the Registration Act as follows:

- 1) The statement "this section does not apply to a duly qualified medical practitioner" should be removed from Section 11, subsection (3).
- 2) Section 12 should be removed in its entirety.

The simple removal of Section 12 is surely not sufficient, however. There is a real problem that must be solved: mobilization of the best possible legal guarantees for the safety of patients. The problem for psychology has been that the medical profession has used its legal position to block efforts of psychologists to establish private practices. The same problem would continue, other things remaining equal, if referral from a doctor were made legally mandatory. But other things would not remain equal, if a licence to practise psychodiagnosis and psychotherapy were made available only to those professions trained to perform them — clinical psychologists, psychiatrists, psychoanalysts and psychiatric social workers. Not

²²OPA Ethical Standards of Psychologists, Principle 2(b).

all clinical psychologists, psychiatric social workers and psychiatrists could qualify, but only those who had undertaken the requisite training. Doctors, *per se*, would not be eligible for licensing, any more than psychologists or social workers, *per se*. In the context of such a system doctors who suspected the presence of a psychological disorder in a patient would be required to refer the patient to a licensed practitioner for further diagnosis and possible treatment.

A majority of the psychologists surveyed supported the idea of licensing psychological services (Table 10.21), although a somewhat smaller majority than those in favour of legal control of services through registration. The principal advantage of licensing is that it could differentiate among services of various types in ways that registration does not. Registration, as pointed out above, is too general. For example, a university research psychologist is entitled to be registered. But he may be totally unequipped to provide mental health services. Hence, if clinical psychologists are to be entitled legally to perform psychotherapy, a system of licensure must discriminate among those who are properly trained and competent to do so and those who are not. Appropriate examining and licensing bodies should be established to this end. It may be that distinct licences should be established for educational, general clinical, rehabilitation and psychodynamic psychology, as well as any other specialties that are sufficiently *sui generis* to warrant it.

If examining and licensing were established for the purpose of licensing psychologists, it should function quite independently of university psychology. University psychology is now so heavily research-oriented that Ph.D. examinations do not examine the capabilities of individuals to perform clinical services such as diagnosis and treatment. Ph.D. psychologists with a research-oriented degree would have to undertake a clinical internship and additional theoretical training in order to become equipped to do clinical work. Thus it would appear desirable to have an examining body separate from the universities which could establish training and internship prerequisites for any candidate for licensure in a branch of applied psychology, and which could conduct examinations when these prerequisites had been fulfilled.

Insurance of Psychological Services

Inclusion of the diagnostic and treatment services of psychologists in medical insurance plans would be the most simple and direct method of rapidly increasing the number of practising psychologists in Ontario. However, the issues involved are not simple.

OMSIP is a medical insurance scheme. It insures the services of physicians and of some medical technicians, such as x-ray technicians working under the supervision of physicians. For reasons that have already been presented and discussed, psychologists object to working under the supervision and control of

doctors. But if that problem could be solved, there would appear to be no objection in principle to insuring certain services by clinical psychologists.

There are two services which, when dispensed by a properly trained clinical psychologist and a properly trained psychiatrist, are identical in nature. These are psychodiagnosis and psychotherapy. If these services are insured under any insurance scheme, then it is the *service* and not a profession (in this case medicine) that ought to be insured. And when, according to a set of reliable criteria, an individual is trained to perform that service, the recipient of the service should be entitled to benefits whether his therapist be a physician, a psychologist, a psychiatric social worker or a non-medical psychoanalyst.

There is an important matter of principle inherent in this question, which finds its current focus in the question of the insurability of psychodiagnosis and psychotherapy by psychologists. This matter may arise many times in the future as scientific and technological advances generate new professional groups with an expertise that overlaps with some part of medicine. The question is, does a pre-paid medical insurance plan insure services, *per se*, which for the most part only doctors are qualified to perform competently and safely; or does it insure the services (some or all) of a profession, such as the profession of medicine?

As far as psychologists' services (psychodiagnosis and psychotherapy) are concerned, this report takes the view that subject to two specific conditions these services should be insured.

First, anyone entitled to insurability of services must be properly and fully trained to perform them. Further, the patient must have been examined by a qualified medical practitioner to eliminate the danger of an organic disorder or physical disease as a concomitant or determinant of the psychological disorder; and this examiner must be prepared to cooperate with the psychologist's treatment to the extent of undertaking such further physical examinations as may be necessary. The psychologist, however, would have to be totally responsible for psychodiagnosis and psychotherapy.

Proper training is, after all, the essence of the matter, along with proper safeguards against the danger of overlooking or not treating a patient's physical health problems. At present general practitioners who for the most part have no adequate training in either psychodiagnosis or psychotherapy (see the above discussion based on Clute's work) may perform these services on an insured basis. The adoption of the first criterion, based on the principle that it is the service and not the profession that is insured, would lead to a change in this practice and require physicians who wanted to secure a psychodiagnosis and/or psychotherapy for his patients either to take specific training in order to perform these services himself, or to adopt the practice of referring these patients to a properly qualified professional. The restriction would have a salutary effect on

the medical profession, on the public, and on the relationship between the two; for it would force a more realistic appraisal of competence in terms of scientific rather than social criteria. Because a physician is trained to diagnose and treat a great range of human disorders and ailments, it does not follow that he is trained to diagnose and treat *all* human disorders.

Patient Responsibility

Psychologists are often diffident about using the work "patient", preferring instead to use the term "client". But underlying the semantic smoke screen, there is a real issue.

Psychiatry claims that historically, ethically and legally, society and patients have always given the ultimate responsibility for patient care to the licensed medically trained physician. The basic position of the American Psychiatric Association relative to psychologists is in agreement with the Report adopted by the House of Delegates of the American Medical Association on June 16, 1960, which states that:

It must be fully realized that physicians have the ultimate responsibility for patient care, and that they, and they alone, are trained to assume this responsibility. In the public interest, other scientists, when contributing to this patient care, must recognize and respect this ultimate responsibility.²³

Psychologists are divided over the question of patient responsibility. While some agree with the medical position and say that it is necessary that they work in collaboration with the physician, others find it indefensible. Nevertheless, even those psychologists who take the former position are not willing to subjugate themselves completely to medicine. Their position can be summarized in the statement of the American Psychological Association published in "Psychology and Its Relations With Other Professions", which endorses the independence of the profession and approves the practice of psychotherapy by psychologists

. . . only if it meets conditions of genuine collaboration with physicians most qualified to deal with borderline problems which arise, e.g., differential diagnosis, intercurrent diseases, psychosomatic problems. Such collaboration is not necessarily indicated in remedial teaching or in vocational and educational counselling.²⁴

The position reached in this report is that psychologists, *when they are properly trained*, legitimately can assume and should assume responsibility for psychodiagnosis and psychotherapy. Paradoxically, the newest type of psychological therapy — behaviour therapy — which has been invented by behavioural psychology does require, in certain applications, either unequivocal medical responsibility or responsibility equally shared by physician and psychologist. There

²³Principles underlying Interdisciplinary Relations Between the Professions of Psychiatry and Psychology, *op. cit.*

²⁴*Ibid.*

is a need for a careful study of behaviour therapy in its different forms by a group of qualified persons (psychologists and psychiatrists) for the purpose of formulating what medical safeguards are indicated.

Special Diagnostic Functions of Clinical Psychologists

Certain acts such as the Mental Incompetence Act are prejudicial to psychologists in the sense that, although psychologists with the appropriate clinical skills can conduct a scientific investigation to determine whether or not an individual is mentally competent, they are not identified as having such a capability in the Act, nor is a court entitled to utilize their services. Therefore, this Act, and any other like it, should be amended to permit the courts to require an allegedly mentally incompetent person to submit to examination by a psychologist.

On the other hand, the Ontario Psychological Association has recommended that

... it become mandatory to obtain the opinion of a psychologist concerning the admission of children to institutions or services for treatment or care of disorders of an emotional or intellectual nature.

Although psychologists should be eligible to provide an opinion concerning the admission of children to institutions, there are other professionals (such as psychiatrists) who are competent on their own to perform this function. It would appear best to have a system in which either or both of psychology and psychiatry may serve this function without making one or the other mandatory.

Conclusion

To a very real extent the Ontario Department of Health is responsible for the current shortage of high quality clinical psychologists, and what is even worse the underdeveloped state of training programs. The U.S. Veterans Administration is a government agency that has established a program for the training of expert clinical psychologists. The benefits to the agency's therapeutic services that derive from its support of the training program are very substantial, as we shall see.

The student enters the four-year program at the end of his first year in graduate school. He is rotated through a neuropsychiatric hospital; a general hospital which includes neuropsychiatric, medical and surgical patients; and a mental hygiene clinic. In addition, he may spend a portion of his training time in one of the specialty programs such as a domiciliary, day treatment centre, restoration centre or day hospital. While he usually receives his training in those installations nearest to his university, distant assignments are available to provide him with specialized training in the field of his interest.

The aim is to provide a broad training tailored to the educational needs of the student. Because the program is a joint endeavour between the Veterans Administration and participating universities, training committees composed of university

and Veterans Administration psychologists are set up to review and evaluate each student's training experience and progress. Also, advisory committees composed of the chairmen of the departments of psychology and Veterans Administration Central Office Psychology Staff meet to review overall program operations.

Specific training programs are developed in each hospital and clinic in coordination with the universities, and are further supported by consultants from the universities who provide professional guidance and training assistance. In addition to his university courses, the student receives intensive training under supervision in psychodiagnosis, psychotherapy, behaviour therapy, vocational counselling and research. Within this framework he may specialize in a particular area, such as the diagnosis and localization of brain impairment, hypnotherapy, attitude therapy, depth psychotherapy, or the newer behaviour modification techniques based upon conditioning principles. Which of these specialized pathways he follows is determined by his academic orientation, his personal interests, and the training opportunities provided by the particular hospital or clinic. The training within the hospitals and clinics is organized and provided primarily by staff psychologists. They may be assisted by psychiatric and medical staff along with consultants from universities and medical schools.

Psychology trainees who complete the Veterans Administration training program simultaneously complete the academic requirements for their doctorate degree in psychology. At the time of writing there were 740 trainees in the program. Since it is not an indentured program, those who take all or part of their training with Veterans Administration hospitals and clinics have no legal obligation to work in the Department of Medicine and Surgery of the Veterans Administration. However, many elect to stay. In 1967, 71 per cent of the agency's 800 doctoral level psychologists came from its own training program. The majority of the program's graduates who leave the Veterans Administration teach in universities or work in other federal or community health facilities. Recently an increasing number have been observed taking positions in the new community mental health centres, many assuming administrative as well as professional positions.

Within the Veterans Administration, psychologists perform diagnostic, therapeutic, vocational counselling and training functions in addition to conducting research. In their day-to-day work they are fully responsible for their professional psychological work with patients. While devoting a major portion of their effort to the emotionally disturbed and mentally ill, they also work with medical, neurological and surgical patients to facilitate psychological adjustment and vocational rehabilitation. The requirements for employment as a beginning psychologist in the Department of Medicine and Surgery in the Veterans Administration are a doctoral degree from an accredited university, plus two years of professional qualifying experience.²⁵

²⁵Personal communication, H. M. Engle, M.D., *op. cit.*

The beneficial influence of a stable, well-designed training tradition supported by adequate financing is clear. Well-trained psychological personnel are recruited into the services of the hospitals and clinics, and qualified staff are available for the new community mental health centres that are now being established throughout the U.S., under the joint auspices of federal and state authorities.

It is not unreasonable to expect that our own Department of Health could profit from the example of the U.S. Veterans Administration. A program of this kind would be a vast improvement over present facilities for training qualified clinical psychologists to serve the Ontario public.

Chapter 11 A New Mental Health Profession

Through our discussion in the preceding chapters of the existing mental health professions, certain basic problems have emerged. There is a large unsatisfied need for mental health services in Ontario. Neither psychiatry nor medicine will be able to meet this need on its own. Social work is not evolving in a direction that would enable it to fill the gap. Psychology, while making great efforts to strengthen and expand its training programs, is still not graduating and probably never will graduate sufficient numbers of clinical psychologists. Psychoanalysis has taken root and is beginning to grow in Ontario; but while it is the core discipline in psychological medicine, its therapeutic resources are unnecessarily powerful and expensive for the treatment of many types of psychoneurotic disturbance. More expert psychotherapists are needed than can possibly be trained by the traditional professions.

But this need in itself would not justify creating a new mental health profession. In addition such a service would have to solve other problems — for example, those relating to training and to interprofessional cooperation.

Training and Career Problems

Psychiatric social workers are performing intensive psychotherapy without the benefits of appropriate advanced training, and usually on the basis of a somewhat haphazard in-service training program. Schools of social work cannot provide this training. The career path via medicine and psychiatry is altogether unrealistic and clinical psychology is only slightly less so. Psychoanalysis is a more realistic option, but it is more specialized and advanced than many of these individuals would want. What is needed is a postgraduate program in psychodynamic psychology and psychotherapy devoted to an intensive practical training in psychodiagnosis and psychotherapy. The same reasoning applies to advanced nursing personnel and to medical practitioners who have developed an interest in mental health.

A special case is the university graduate in humanities and in the social and psychological sciences who wants a professional career in mental health but who, for a variety of legitimate reasons, does not find the career options presented by medicine, psychology or social work attractive. A new professional career opportunity is needed for these young people. They could represent a positive addition to the corps of mental health professionals.

Interprofessional Cooperation

Despite the best efforts, best intentions and fine rhetoric of the traditional mental health disciplines, there is a chronic lack of effective cooperation and collaboration among them. It is only realistic to suppose that unless some new factor is introduced, this problem will remain largely unsolved. A new profession developed out of interdisciplinary training might effect better interprofessional cooperation. For example, professionals trained, in part, shoulder to shoulder with medical internes would be in a better position to enjoy the confidence and collaboration of doctors. The referral mechanism which has been acknowledged as a necessary safeguard for the introduction of non-medical mental health practitioners into hospitals or private practice will genuinely cease to be an undesirable barrier to non-medical professional work only when a high level of confidence, mutual understanding and cooperation has been established. If a new profession trained in an interdisciplinary program could achieve this end, this accomplishment alone would justify its existence.

A model for such a profession has already been developed by L. S. Kubie, an eminent American psychiatrist and psychoanalyst.

Proposal for a New Mental Health Profession

Kubie proposes that the medical schools and the departments of behavioural science and the humanities should join forces to develop a new scientific and healing subdiscipline under a new title which he labels a Doctorate in Medical Psychology. Kubie has outlined and defended his proposal in a number of different publications.¹ Only the salient general features are summarized here.

The establishment of such a training program for a new profession of psychotherapists is seen by Kubie as a long-term solution which will begin to have real results in ten to fifteen years and will make a significant difference in twenty-five years. It is not envisaged as a crash program, short-term solution. In Kubie's view, improved rather than diluted standards of practice are needed. Thus he envisages a training program for a cadre of teachers who will become responsible for training the new profession. This would take from five to ten years to accomplish. Each member of the training faculty would become in this way a genuinely interdisciplinary mental health scientist, with clinical as well as theoretical and research expertise. The teachers in training would be drawn from the relevant medical, scientific and humanities departments. The teachers of the teachers

¹"A School of Psychological Medicine Within the Framework of a Medical School and University", *Journal of Medical Education*, Vol. 39, No. 5, 1964, pp. 476-480; "The Pros and Cons of a New Profession: A Doctorate in Medical Psychology", *Texas Reports on Biology and Medicine*, Vol. 12, No. 3, 1954, pp. 125-170; "The Overall Manpower Problem in Mental Health Personnel", *Journal of Neurosis and Mental Diseases*, Vol. 144, No. 16, 1967, pp. 466-470; "The Search for Maturity in Pre-Professional Education", *Clinical Research*, Vol. VII, No. 2, 1959, pp. 177-183.

would be senior psychiatrists and psychoanalysts. The advantage of this first step would be to provide a basis in shared knowledge and expertise among faculty members for a closely integrated curriculum and training program.

Students would be drawn from undergraduate courses in the behavioural sciences, schools of social work, and the humanities, and from medicine. Because the training would be sponsored jointly by medicine and departments of the faculty of arts and science and the school of social work, the students would be subject to the influence of the three major bodies of knowledge and practice that intersect in the work of the mental health practitioner. Kubie stresses the importance of having the clinical aspects of the training located in a medical school and teaching hospital. There are two basic reasons for this part of his proposal:

Such daily contacts will gradually and automatically impart many of the traditions of scientific medicine, just as happens to the medical student: such as the sense of dedication to therapeutic goals; a deep and automatic respect for each human being's right to privacy; and, finally, and perhaps most important of all, a tough-minded skepticism about naive, unjustified, and exaggerated therapeutic claims.²

Also, by working side by side with medical students, the Doctor of Medical Psychology would become empathetic with the physician, and not his rival — that is, this training would solve the problem of professional cooperation. It is not clear that the first reason is of prime importance — attitudes of dedication to serving the needs of others, respect for the autonomy and privacy of others, and scientific skepticism are moral and intellectual virtues to which medicine has no special claim. But the second reason is surely of fundamental importance for the rational development of adequate mental health services. And as long as doctors are taught to *believe* that they enjoy the moral and intellectual virtues enumerated by Kubie to a degree unequalled by any other profession, then because of their essential role in health services generally and in mental health services specifically, a training program that earns their confidence and respect is to be preferred as most practical under the circumstances.

Kubie has outlined his conception of the curriculum for the training of such a profession.

The over-all curriculum would consist of the following components:

A. Preprofessional (undergraduate)

The basic physical and chemical sciences, comparative biology, experimental methodology; the behavioural sciences, including experimental, clinical, social, developmental, and child psychology, cultural anthropology, and primitive psychology; comparative animal psychology and ethology; philology; higher mathematics and statistical methods in general, and the humanities.

B. Professional.

²L. S. Kubie, M.D., "Need for a New Subdiscipline in the Medical Profession", *A.M.A. Archives of Neurology and Psychiatry*, September 1957, Vol. 78, p. 289.

1. Preclinical (first and second years)

(a) A course in basic medical science (comparative to that now offered in Harvard Medical School to men who want to work in medical research but not in the practice of medicine).

(b) Medical and psychiatric sociology (with social casework).

(c) Further techniques of psychological testing.

(d) Graduate work in the disciplines under A, above.

2. Clinical: Prepsychiatric (second and third years)

(a) A sense of at-oneness with human beings who are suffering from organic disease is essential for the emotional and intellectual preparation of a future doctor of medical psychology. This is essential also as a comparative basis for a later understanding of human beings who suffer from psychological ailments. Therefore, the student would first be exposed to patients on medical and surgical wards of general hospitals, i.e., who are suffering from organic diseases. Here his successive functions would be three: (1) first, as an orderly or nurse's aide, (2) then as a clinical clerk, learning how to gather critically the interdependent story of human lives and of their organic complaints, and (3) administering and scoring psychological tests to such patients.

(b) This experience would then be enriched and supplemented by direct contacts with patients and their families in their own homes. The initial contacts would be organized under the general medical social service, subsequent ones under psychiatric social service, in connection with the care both of ward and of out-patient.

In the course of time through such experience on wards, in the out-patients department, and in the home, patients suffering from organic diseases, with or without concurrent neuroses and psychoses, would no longer be new to such a student. They would be human beings with whom he had lived and worked for at least two years, experiencing their daily fluctuations in health and illness. In later years when he encounters manifestations of organic disease as complications of psychiatric illness, they will be familiar to him; and he will not neglect them or deny them, because he will not be frightened by their unfamiliarity.

(c) Work is continued on a graduate level in the basic disciplines listed above under A. Note that there would thus be four years of maturing in the preprofessional or basic disciplines, spotted through the years of professional training.

3. Clinical-Psychiatric (fourth through seventh years)

The third step in training (i.e., probably starting in the fourth year of the professional curriculum) would take the student to the psychiatric division of the hospital and to its psychiatric out-patient department. There he would go through steps in training which would parallel what he had been through on the medical and surgical services: to wit, working first as an attendant, then as a clerk, and then as a psychological tester and psychiatric social worker.

Thus every phase through which the student passes would include training in interviewing, in taking life histories, in subjecting patients to psychological tests, in the evaluation of these tests, and, above all, in observing and in understanding the incessant subtle interplay among patients, and among patients, attendants, nurses, and therapists.

4. Psychodiagnostic and Psychotherapeutic (fifth year and on).

The definitive training in psychodiagnosis and in psychotherapeutic techniques would thus be based upon a wealth of diversified clinical experiences on wards, in out-patient clinics, and in homes. Here, as in the training of initial cadre of teachers, the study of tape recordings and of sound films of diagnostic and of therapeutic interviews would play a major role, with additional opportunities to observe therapeutic interviews through one-way screens, to study filmed interviews, and to participate in seminars based on week-by-week reports and data from the treatment of patients, as conducted both by experienced therapists and by other students.

These steps would lead to the conduct of psychotherapy under supervision, which, in turn, would be subjected to the same rigorous challenge of critical group discussion.

5. For many the final step would be psychoanalytic training. For all there would be training in such special techniques as the use of hypnotherapy and methods of group psychotherapy.³

The major advantage of this curriculum, apart from its obvious merits as a training program for psychotherapists, is that it would attract numerous highly gifted students who are interested in a professional career in mental health but who are not interested in medical training, in social work, or in a Ph.D. in psychology. Thus it would attract into the mental health services many young people who would otherwise be lost to it.

But it would not adversely affect recruitment to medicine, psychiatry, social work or psychology. Although these practitioners would be as thoroughly (if not more thoroughly) trained to perform psychodiagnosis and psychotherapy as psychiatrists who are psychotherapists, their training would not require as much time and would not be as costly. The training of a psychiatrist requires a minimum of eleven years, whereas the training of a psychotherapist on the Kubie model would take a minimum of eight years. Given the fact that Ontario's undergraduates have received two full years of education more than most of their American counterparts, the adaptation of Kubie's curriculum to Ontario's system of education could safely involve some reductions in the time allotted by him to the professional postgraduate component. Further reductions could be introduced through the use of a summer internship program to utilize the longer summer vacation period in Ontario. Thus it is likely that the training of such a profession would begin to meet the rapidly expanding need for psychotherapeutic services in Ontario. A pilot project could be undertaken at an early date at one of Ontario's universities which has a medical school, a faculty of arts and science, and a school of social work which could cooperate to inaugurate it.

Field interviews showed a broad basis of support for the Kubie plan among psychiatrists in Ontario and in the U.S. Psychologists were more reluctant to support it because of the fear that the "medical model" of mental illness and

³*Ibid.*, pp. 289-290.

health inevitably would dominate such a program. This fear, however, was expressed also in relation to developments in clinical psychology in the U.S., where clinical psychologists base their work on psychodynamic models shared by them with psychiatry. But there are those who think that the so-called "medical model" should be the basis of these practices because it provides the best understanding of psychopathology available, and a number of Ontario's leading clinical psychologists would support the plan.

The problem of professional identity, examination and regulation could be solved by establishing an examining and licensing board empowered to grant licences to Doctorates of Medical Psychology who satisfied its standards of practice. This board could issue licences also to clinical psychologists who qualify as psychotherapists. The licence could be formulated and granted in terms of explicit regulations governing the conditions of practice. In particular, it could establish and enforce the requirement that at the same time as a psychological examination of a patient is undertaken, and prior to the commencement of psychotherapy, every prospective patient must receive a complete physical check-up by a physician. It could also require such check-ups at regularly prescribed intervals throughout the course of the psychotherapy and at its termination or interruption. The use of medications when required (and usually they are not) could be handled also through cooperation with the examining physician. When more powerful drugs or any physical therapy such as ECT are indicated, then this component of the treatment would have to be undertaken by a psychiatrist.

In addition, there is the problem of psychiatric emergencies. Although the psychotherapist would be limited in his practice to the treatment of psychoneurotic disorders, there are always borderline cases in which an unsuspected psychotic disturbance which has been masked by apparently superficial maladjustments suddenly erupts. And sometimes, during a consultation, a patient undergoing a severe and dangerous psychotic episode may present himself. These would not be frequent occurrences, but they can arise and the psychotherapist would have to be able to deal with these psychiatric emergencies. Three possibilities exist: 1) psychotherapists could be limited in their practice to working in a psychiatric service in which psychiatrists are present—that is, they could be denied the opportunity of private practice; 2) psychotherapists could be required to establish a close liaison with a psychiatrist who is prepared to handle emergency cases; 3) psychotherapists could be allowed to commit patients to mental hospitals, and thereby take care of emergencies themselves.

It would appear that, for a number of reasons, the third alternative is the best course. It is important that psychotherapists should not be denied the option of private practice, since this is a service that many people want and one that is well suited to the treatment of psychoneurosis. The Doctorate of Medical Psychology would gain experience in medical emergency admissions and through it would become aware of the responsibilities of handling such cases. It is just

this sense of responsibility for the well-being of patients that many psychiatrists claim to have found wanting in clinical psychologists as they are now trained. Kubie's program is designed specifically to inculcate this attitude. The psychotherapist so trained thus could be safely entrusted with the power of committing a patient to a mental hospital on an emergency basis only. The patient subsequently would have to be examined by a psychiatrist attached to the hospital, and further disposition and treatment of the patient would have to be based on the assessment made by the hospital's diagnostic service. Under these conditions and with these safeguards, there would be no reason why psychotherapists could not establish private practices.

Nor would there be any reason why their services could not be insured by OMSIP, since their psychodiagnostic and psychotherapeutic work with psychoneurotic patients would be of equal quality with that of psychiatrists who were trained to do psychotherapy. The particular advantage that these new professional psychotherapists could have in Ontario, as compared with psychologists and social workers, is that, because of the elements of common training experience, they would be known by physicians and would enjoy their confidence; but unlike physicians, they would be at home in a wide range of non-medical settings, such as school mental health clinics or social agencies. Consequently, they could fill a major gap in the province's mental health services.

Huron County has been discussed elsewhere in terms of the difficulties it has encountered in attracting adequate mental health diagnostic and treatment personnel. The introduction of a number of professional psychotherapists who, working in close cooperation with the psychiatrists at the Ontario Hospital at Goderich, the local physicians and Medical Officer of Health, the Children's Aid Society and the local school boards, could make basic improvements in the scope and quality of mental health services to the population of the county. Huron County exemplifies similar needs in other rural and urban areas throughout the province.

These considerations support the observations made earlier in this report that the creation of a new profession of non-medical psychotherapists trained on the Kubie plan could be the single most important step that could be taken to improve the quality and scope of Ontario's mental health services. Because of inflation, it would not accomplish the letter of Leighton's dictum, that what is now most needed in mental health is high quality five-dollar psychotherapy. But it just might accomplish the spirit of his hope for society.

Part Three: The Mental Health Services

Chapter 12 Hospital Services

Trends

When the study on trends in psychiatric care reported its findings to the Hall Commission in 1964,¹ it confirmed that Ontario was moving away from the big mental hospital; but it was uncertain as to whether the pattern at that time was to build more small community mental hospitals of 300 to 400 beds or to set up more psychiatric units in general hospitals. There has been expansion of all three types of hospital facilities since then, and it would appear from Table 12.1 that that the same uncertainty remains in government policies regarding trends in institutional care.

TABLE 12.1
Growth of Psychiatric Hospital Facilities in Ontario since 1960

Type of institution	Year		
	1960	1965	1967
Ontario Hospitals	13	15	15
Community psychiatric hospitals	0	3	4
Psychiatric units in general hospitals	17	22	25

SOURCE: Ontario Department of Health Statistics.

The two Ontario Hospitals completed in 1964 have 305 beds (Goderich) and 300 beds (Owen Sound) respectively. They are, therefore, quite different from the older type of Ontario hospitals of 1,000 or more beds. It would seem that the Ontario government has recognized the inadequacy of big mental hospitals, but only as far as erecting new structures is concerned. Nothing has yet been done to replace the existing Ontario hospitals or to reduce their size. (Such reductions were recommended by the Hall Commission.)² Even though the Ontario Hospitals

¹D. G. McKerracher, *op. cit.*

²*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964.

at Goderich and at Owen Sound are smaller, they are still under the control of the Department of Health and they are required to serve the needs of a region rather than the needs of the communities in which they are located.

The community psychiatric hospitals came into being after the introduction of the Community Psychiatric Hospitals Act of 1960-1961. This Act was first intended to provide sanatoria with spare beds which could be utilized to treat patients other than those suffering from tuberculosis. It now provides authority for the government to reimburse local boards operating mental hospitals under this Act for their net allowable operating costs, including the cost of medical services. Much has been said about the advantages of community mental hospitals.³ In 1965 there were three community psychiatric hospitals reporting to the Department of Health: the Royal Ottawa Sanatorium, the Sudbury-Algoma Sanatorium, and the Windsor I.O.D.E., with a total bed capacity of 175. None has a bed capacity of more than 100.

One of the recommendations made by the Hall Commission was that there should be an increase in the number of psychiatric units in existing general hospitals. This recommendation has been adopted by the Ontario government. The trend in recent years has been to treat mentally ill patients requiring short-term or intermediate care in general hospitals.⁴ The establishment of psychiatric units in general hospitals is part of the province's answer to the proposition that community resources should be developed to offer a broad range of diagnostic and treatment services, and continuity of care, by gradually abandoning the mental hospitals and by shifting the full responsibility for the care and treatment of the mentally ill to general hospitals. This trend has inherent limitations, however, because general hospitals are reluctant to admit to their psychiatric units children, adolescents, patients with behaviour disorders, geriatric patients or patients suffering from acute psychiatric disorders requiring long-term treatment.⁵

The proposition that psychiatric wards in general hospitals provide the best facilities for psychiatric treatment and care — a proposition which the Ontario government seems to endorse — was rejected by the World Health Organization as early as 1953.⁶ The two reasons given then are still applicable to the situation in Ontario. First, psychiatric wards of a general hospital are forced by the expectations of the hospital authorities to conform to a pattern which is harmful to their purpose. "Patients are expected to be in bed and nurses are expected to be engaged in activities which resemble general nursing. The satisfactions of neuro-

³See F. S. Lawson, "Mental Hospitals: Their Size and Function", *Canadian Journal of Public Health*, Vol. 49, May 1958, pp. 192-195.

⁴OHSC 1965 Annual Report.

⁵From a presentation by Dr. H. W. Henderson to the Annual Meeting, Canadian Psychiatric Association, June 17, 1967.

⁶*Third Report of the Expert Committee on Mental Health*, World Health Organization Technical Report Series, No. 73, New York, September 1953.

logical diagnosis are enhanced by the prestige in the general hospital of clear-cut physical pathology, to the detriment of interest in the average psychiatric patient whose case does not exhibit such features; and it is difficult to obtain recognition of the overwhelming importance in psychiatry of the factors involving the therapeutic atmosphere." Second, general hospitals tend to treat and return to society a high proportion of psychiatric patients capable of early recovery and send to the community mental hospital only those patients who are grossly disturbed, chronic, or of apparently bad prognosis, thus turning the community mental hospital into a "madhouse" for the chronically insane.

TABLE 12.2
Comparison of Treatment Patterns in Ontario Psychiatric Inpatient Facilities, 1966

Type of institution	Bed capacity	Patients admitted for active treatment
Ontario Hospitals for the mentally ill ¹	11,308	13,368
Psychiatric units of general hospitals	662	8,687
Community psychiatric hospitals ²	175	1,128

¹The bed capacity of 11,308 excludes beds (3,526) in residential units of these hospitals.

²Excludes Clarke Institute of Psychiatry which commenced reporting in June 1966.

SOURCE: Bed capacity of Ontario Hospitals from DBS, *Mental Health Statistics*, Vol. III, Queen's Printer, Ottawa, 1966; other data from 99th Annual Report, Mental Health Division, Department of Health, Ontario, 1966.

The applicability of these criticisms to Ontario is indicated by the figures in Table 12.2. Psychiatric units of general hospitals, with about half the number of beds, were able to actively treat more than two-thirds the total of patients given active treatment in Ontario Hospitals, largely because of the selective basis on which patients are admitted — that is, only patients who respond favourably to treatment and are capable of early recovery and discharge. The difficult patients are left to Ontario Hospitals.

While the government is unable to adopt a clear-cut policy on the direction in which institutional facilities should develop, it has sought to meet demands by expanding all three types of facilities. Thus, we find that a new Ontario Hospital is being built at Porcupine to serve northeastern Ontario. This decision is in keeping with the policy for further development and integration of mental health services throughout the province on a regional basis. To this end, the Department of Health has divided the province into designated regions and has estimated the needs for inpatient accommodation.⁷ The Department of Health is

⁷Statement by Minister of Health on the introduction of 1966-1967 estimates of the Ontario Department of Health.

trying to work out the establishment of medical-dental centres which would serve a population area requiring the services of two or three physicians, one or two dentists, and a number of nurses. It is hoped that this development would encourage a more equitable distribution of health personnel.

The plan has the support of university health sciences centres, because success on the part of the Department of Health would enable universities to demonstrate to graduates the advantages of going to remoter regions to practise, especially if such regional centres maintained an association with universities. In order to attract physicians to these centres, the Department of Health plans to provide financial incentives by raising the salary level and by allowing physicians to carry on a fee-for-service practice at the same time. Physicians would also be able to retain their association with universities for further training purposes. The Department of Health has already contacted some health sciences centres in universities which are prepared to take on one or two of these medical-dental centres as pilot projects.⁸

Inpatient Needs

There has been a marked decline in the mental hospital population in the U.K., in the U.S., and in Canada during the past decade. In 1964, when the research study on "Psychiatric Care in Canada — Extent and Results"⁹ reported to the Hall Commission, it was noted that the Hospital Plan for England and Wales had taken a ratio of 1.8 beds for 1,000 population as a probable limit of requirements by 1975 (1.34 beds for treatment up to three months in duration, 0.53 beds for treatment up to two years, and 0.89 beds for long-stay patients). The study also estimated inpatient needs in Canada, based on utilization data for Saskatchewan. The estimate stands at 0.55 beds for *intensive treatment* per 1,000 population, based on admission rates from metropolitan areas, and hospital care including continuing care for patients with psychoses of the senium and for those suffering from mental deficiency. It was felt that this ratio would also give sufficient provision for the intensive hospital care needed by readmissions, if suitable alternatives were developed for the care of the aged and retarded. It was also estimated that this 0.55 beds per 1,000 population could be reduced by more extensive outpatient and community services.

If these estimates were applied to Ontario, we would need 12,600 beds for active treatment, continuing care and long-stay patients according to the U.K. ratio, based on a population of 7,000,000. According to the estimates for intensive treatment, we would need only 3,850 beds. We have seen that Ontario already has a bed capacity of about 13,860 in Ontario Hospitals, in psychiatric

⁸Transcript of Hearing, Department of Health, December 12, 1967, pp. 114-117.

⁹Alex Richman, "Psychiatric Care in Canada: Extents and Results", Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 317.

units of general hospitals, and in community psychiatric hospitals. Since the Ontario Department of Health has a policy of transferring from hospital wards to residential units patients who have a diagnosis of schizophrenic disorder, senile psychosis, or psychosis with cerebral arteriosclerosis (in which case they cease to be included in patients listed on the hospital's books), we can assume that all these 13,800 beds are intended for active treatment. Whether or not such treatment actually is given is a different matter.

With a bed capacity of 13,800, Ontario appears to have enough hospital beds to treat the mentally ill without need for further physical expansion. However, this does not mean that the quality of psychiatric care in Ontario is of a very high, or even of a sufficient, standard. It is useful, therefore, to present some data concerning care and treatment in hospitals derived from field interviews.

The purpose of this section is not to provide complete descriptions of psychiatric units or to enumerate all such units. It is rather to provide some highlights concerning treatment facilities, staffing arrangements and treatment practices in a fairly representative sample of such facilities in the province. Hospitals in Toronto, Ottawa and Kingston were selected.

General Hospitals

Treatment Policies

Admission policies concerning patient selection vary somewhat from hospital to hospital. In general, patients that present custodial problems, patients whose treatment will require more than six months, and patients seen to be lapsing into an irretrievable chronic state will be transferred to Ontario Hospitals. A number of hospitals prefer not to treat psychoneurotic patients in hospital on the grounds that they are better treated through the outpatient service. Other hospitals admit psychoneurotic patients usually for the purpose of treating depression by means of electroconvulsive therapy or during a period of crisis for observation. Psychoses requiring short-term treatment, the less severe character disorders, and in some instances neuroses are the illnesses most likely to be treated in the psychiatric unit of a general hospital. Our field work supported the conclusion that the Ontario Hospitals are used by the general hospitals as repositories for the most severe and chronic cases, and generally for illnesses that do not respond to short-term treatment.

The word that was most often used to describe the prevailing therapeutic approach in almost all the general hospitals was "eclectic". It was generally agreed that the eclecticism was not primarily the result of the existence of numerous different and competing theoretical positions adopted by persons on the hospital staff, but was more the result of a pragmatic approach to treatment on the part of most staff members. Although it was indicated that some staff members had

distinct preferences and aversions as far as certain forms of treatment are concerned, on the whole the approach was enormously tolerant, broad, and sometimes uncertain and vague.

Pharmacological therapy and the various psychotherapies are the forms of treatment that are almost universally used. The general hospitals' policies of excluding the alcoholic, the severe character and personality disorder, and the chronically ill patient, combined with the use of drugs to control patients, have allowed the hospitals to institute an open ward policy, with few custodial restrictions on the patients. However, the constraints imposed by drugs are considered by some to be scarcely an improvement on constraints imposed by orderlies, especially if the orderlies are part of a milieu program.

The intensity and the frequency of individual or group psychotherapy and of counselling depends upon the orientation of the hospital staff and the availability of psychiatric time. In addition to the psychotherapies, there are a number of physical treatments. The most important of these is probably drugs. As K. M. McGregor, superintendent of the Ontario Hospital at St. Thomas has written:

A slow increase in our discharge rate began prior to the use of psychotropic drugs, but the discharge rate accelerated concomitant with the use of drugs. Their value, however, cannot be discounted, as they have broken the barrier between the practising physician and the mentally ill patient, providing him with a form of continuing treatment in which he can participate. They have facilitated psychotherapy (though this point is denied by certain psychiatrists who argue that most patients on psychotropic drugs respond badly to psychotherapy) and have augmented and supported the many facets which now go to form the "therapeutic community", a concept not dissimilar to the "moral treatment" of more than a century ago.¹⁰

The point in question is whether a complete medical training is necessary for the therapist before he can prescribe these drugs. There is some argument that a specialist in the field of mental health in the course of two weeks can learn enough about these drugs to be able to prescribe them effectively and safely. It is, of course, doubtful that the medical profession as a whole would ever admit this extreme position.

Drugs play a very important role in the treatment of the mentally ill in the province, and might conceivably play a much larger role in the future. To this extent, the existence of medically trained psychiatrists is essential.

The other major form of medical treatment is electroconvulsive therapy. Although this treatment fell into disuse with the introduction of drugs, it is now being used with increasing frequency, especially for the treatment of depression and catatonic schizophrenia.

¹⁰K. M. McGregor, "Trends in Mental Hospitals", *Canadian Psychiatric Association Journal*, Vol. 9, No. 4, August 1964, pp. 331-335.

The advantage of ECT as a form of treatment, in the opinion of psychiatrists who use it, is that it is inexpensive, easy to administer, of short duration, and in most cases, effective in relieving the symptom of depression.

It must be pointed out that some psychiatrists would never use ECT, because of the danger of destroying brain cells that sustain memory; and not a few would never use it for psychoneurotic illnesses that can be successfully treated by psychotherapy or psychoanalysis.

Certain other forms of psychiatric treatment in hospital are obviously of a medical nature. These are surgery and subcoma insulin. Surgery is used only rarely in the province, and is an expensive form of treatment, each operation costing about \$2,000. It is only used in *extremis* for patients who have undergone long and intensive treatments, who show many refractory symptoms, and who are undergoing great suffering. Even then, it is performed only if there is general agreement among the psychiatric staff that this step is necessary. It is not completely discredited as a form of treatment, but it is very rarely used.

Subcoma insulin is used to regress patients who are difficult to handle because of mental illness. As a form of treatment, it is used very rarely, but probably more often than surgery. Coma insulin has been completely discredited and appears never to be used.

The field interviews agreed well with the tabulated results of the questionnaire survey (Table 4.8). The trend is towards a gradual reduction in the use of narrowly medical therapies for bed-ridden patients in hospital wards and the maximum use of psychotherapy and counselling through outpatient clinics.

Services

The inpatient services usually consist of thirty to forty beds geographically located in a single area, with lounge and some recreational facilities adjacent or nearby. The average duration of hospitalization appears to be about three weeks, in part because of the treatment policy described above.

These hospitals already have or are developing outpatient services. Many hospital psychiatrists stress the importance of high quality outpatient services as the best means of reducing the need for hospital beds for the mentally ill. These clinics are used also to provide drugs, medical supervision, and counselling for persons suffering from a psychosis that has been brought under control.

Professional Policies

All the hospitals visited employ the services of all the mental health professionals. Almost all hospitals needed more professional personnel, especially psychologists, social workers and nurses. Because of the general shortage of psychologists and social workers, they are considerably outnumbered by psychiatrists in every hospital visited. The Ottawa General Hospital was the only hospital visited that is

fully committed to the policy of deliberately mobilizing the therapeutic resources of non-medical professional personnel. A number of the teaching hospitals reported vacant places for residents in psychiatry. This circumstance does not augur well for the future, especially if psychiatry continues in its present dominant role.

Most hospital staff viewed themselves primarily as members of a medical community. With a few exceptions, the psychiatrists generally commended the social workers and the psychologists on the excellence of their work and considered their services to be necessary ancillary functions to their own. The doctors in the hospital setting on the whole had a medical orientation, as could be expected, and insisted that about 30 per cent of their work was concerned with matters of a medical nature, for which only they were trained. Most pointed out that by legal and professional responsibility they had to assume command of the treatment team, and few doctors in the hospital setting seemed willing to change the locus of responsibility completely. Most, however, were willing to assign more responsibility to the ancillary professions, to the extent that they were confident that these staff were adequately trained for diagnostic and treatment roles.

Although the practices in most hospitals were similar, almost any generalization about psychiatric practice would ring false, since within the mosaic there is a range for shading. What is done in one hospital by a psychiatrist may be done in another by a nurse, psychologist or social worker. Whether nurses, social workers and psychologists will be used for various forms of psychotherapy depends mostly upon the individual psychiatrists involved. Secondarily, of course, it depends upon the characteristics of the ancillary personnel themselves. In many cases it is not so much their training or their background as their personalities and interests which induces the psychiatrists to let them engage in the various forms of psychotherapy. The higher the professional status of the person involved, and the more comprehensive his training, the more wary some psychiatrists are of using him for psychotherapy. In other words, a good nurse with a feel for the work will meet less resistance than will a highly trained psychologist. In many cases, however, psychologists are engaging in these forms of treatment, theoretically under the supervision of a doctor, but in practice only upon referral.

In many cases, the psychologists are convinced that their training and abilities are not properly appreciated. It is hard to assess this claim. Many psychiatrists do seem to be aware of the abilities and limitations of those psychologists with whom they are in close working contact. Often the psychiatrist feels that the psychologist wishes to do a job for which he is untrained. Often there does not seem to be the cooperation between the various members of the hospital staff that one would expect in the best interests of the patients. Some psychologists are unwilling to let their students be trained for psychotherapy by psychiatrists; psychiatrists, on the other hand, emphasize their legal responsibility to assert their dominance within the hospital setting.

It would probably be incorrect, however, to say that these are ideological positions. More accurately, one would describe them as reflections of existing practice. Professional hostility and resentment, and lack of awareness of the training and abilities of the members of the various professions, probably cause some hardship; but it would seem that personal conflicts and personal disagreements about treatment methods are far more significant.

The difficulty arises from the fact that when a staff psychiatrist complains about the role that a particular staff psychologist wishes to play, it is next to impossible to determine whether he is actually objecting to psychologists *per se*, or whether he is objecting to that particular psychologist.

Similarly, the practice differs among hospitals concerning the role of social workers. Some content themselves with traditional social work activities, like social history taking, and the counselling of friends and relations, while others engage in intensive psychotherapy, both with individual patients and with families. Social workers who are trained for this more intensive role find more ready acceptance, but this is probably because there are so few of them who are properly trained, and because many of those who are well trained are not sufficiently assertive to challenge the doctor's position.

Doctors are more than willing to admit that the social worker is the person who is most competent to manipulate the home atmosphere, and to work with role definition. In the same way, psychologists are given free rein with their tests for diagnostic purposes, and with the peculiar forms of treatment, such as behaviour therapy, which stem directly from their training and experience. They are also seen as the people best prepared to lecture to the staff on the behavioural sciences, and their value in conducting research projects is challenged by only a few psychiatrists. (The latter claim that they would be more happy with one psychometrist and one properly trained statistician than with a Ph.D. psychologist.)

The nurse is in the most ambiguous position. On the one hand, she is the person with the most daily contact with the patient. On the other hand, she is the person who is by far the most poorly trained. In fact, her formal training may consist of a three-month affiliation course during her training period, of which 80 per cent or more will have been spent in clinical work. It is only the unimaginative psychiatrist, however, who is content with the traditional bedside care orientation of most nurses. One psychiatrist expressed the view that regardless of the training that a nurse received, whether it was from a university or from a hospital, it took a good three months to break the nurse of the rigid habits of thought which she had acquired. It was only after this process had been completed that the training for dealing with the emotionally ill patient could begin. Most psychiatrists seem to be ambivalent towards nurses as a whole. Although they recognize the important role which the nurse potentially can play, they are also limited by their professional image of the nurse's role as the doctor's helper, and are

therefore unwilling to allow nurses to take too much initiative. Further, nurses themselves subscribe to this view of their professional role, and are unwilling to take any responsibility or to act independently, if there is the possibility that they will be opposed at any stage in the process by the doctor, whose training, status and authority they hold in the highest regard. The use of nurses ranges from traditional medical nursing among doctors and nurses of what might be called the old school, to low-keyed individual and group psychotherapy among younger nurses working with progressive doctors.

Problems of Professional Cooperation

In many cases there is not sufficient coordination among the various professions over the treatment of the patient, and the ancillary professions are often kept in the dark concerning the approach that the psychiatrist is taking an individual therapy, or in group therapy with a particular patient. There is always the danger that the nurse, the psychologist, the social worker and the doctor may all be working at cross-purposes.

Of course there are staff conferences, diagnostic conferences, and grand rounds in the hospitals, as well as informal conferences between the doctor and the other members of staff concerning the patient's treatment; but it seems that there is often too much pressure of time to allow full and complete discussion.

For a number of reasons, the files that the psychiatrists keep in the hospitals are often incomplete and sketchy. First, the confidentiality of the psychiatrist-patient relationship is not protected by law; hence the psychiatrist's files might be subpoenaed in a legal action. As a result, doctors usually enter only the barest diagnosis in the hospital records. Second, the hospital files are open to many of the hospital staff of a low level, such as nursing assistants and orderlies, who should not be trusted with privileged communications. There is also a chance that the clerical staff, who might not appreciate the significance of the data entered in the files, would use this information in an unacceptable way.

A further impediment to interprofessional communication is lack of time. Nurses have expressed the desire to read the reports of the psychologist's tests of the patients; but since the psychologists often have their offices or keep their files in geographically discrete portions of the hospital, the nursing staff usually do not have the time to read them. Moreover, most hospitals do not have medical records retrieval systems, or libraries, that are efficient enough to facilitate the flow of information about patients, the progress of their illness, and its treatment.

Another problem, which is probably intractable, is that any conference consisting of a nurse, social worker, psychologist and psychiatrist, as well as students of these various professions, is an enormously heterogeneous group. Not only the technical language but the level of sophistication differ greatly from, say, the student nurse to the analytically trained psychiatrist. And although some psychia-

trists have the facility of communicating with people with much less training than themselves, many do not. The time spent in communication is at best neutral, and may indeed be harmful; for if a nurse, with no understanding of psychodynamics, thinks that on the basis of her talks with the psychiatrists, and her awareness of the terminology, she is capable of interpreting to a patient his unconscious psychopathology, she may do a significant amount of damage to the patients under her care.

Despite these problems a good deal is being done in some hospitals to provide interdisciplinary training for the members of staff, with a view to training better therapists. Without prejudice to the functions which the particular person can do better than anyone else (such as testing for the psychologist) the other members of the professions are being prepared for psychotherapy or, more generally, for counselling.

Use of Videotape for Teaching and Therapy

Perhaps the most potent technological improvement to assist learning in this field is videotape. The potential of this sort of equipment for use in both teaching and therapy is considerable.

In the first place, it allows the student to observe his total interaction with the patient, verbal as well as non-verbal. The fact that the tape can be stopped at any point and analyzed is an enormously beneficial teaching device. Some system to allow an interchange of tapes among hospitals would be useful, so that a particular type of disease or a particular therapeutic technique could be analyzed. The main impediment to this scheme is that the various videotape systems now in existence are incompatible. An attempt should be made to synchronize the use of tapes at the various hospitals.

The second use for videotape equipment is in therapy. The patient and the therapist spend the first part of the session in normal therapeutic activity, but then spend the second half of the hour viewing the tape and discussing the relevance of the material contained therein.

To ensure the most efficient use of the tapes for teaching purposes, two steps should be taken. The first is the establishment of a committee composed of representatives from all teaching hospitals to facilitate communication, and to arrange for the installation of compatible types of equipment. Second, either a catalogue or an abstract of available tapes for loan to other hospitals should be prepared and kept up to date. No attempt should be made to impose any form of centralized control over these tape libraries, for the interests of teaching and research are best served by allowing each hospital to develop unique and distinctive approaches; and the perpetuation of such a special flavour in teaching is one of the main ways in which those hospitals that are less well-endowed financially can hope to attract good students.

Ontario Hospitals

Treatment Policies

The Ontario Hospitals must treat all types and conditions of mental illness, including those that present serious custodial problems. They also find themselves providing homes for old people who need not be in hospital but who have nowhere else to go. The problems they must cope with are further exacerbated by the fact that they tend to receive the most severe, deteriorating and chronic illnesses referred by the general hospitals. In addition, most of these hospitals serve large geographical areas and therefore must cope with large numbers of patients.

In general the approach to therapy in the mental hospitals is the same as that in the general hospitals. The differences that exist derive from the greater numbers of psychotic and chronic patients in the Ontario Hospitals. For example, the Ontario Hospital, Kingston, has a patient population approximately as follows: 13 per cent are acutely ill but are undergoing active treatment; 34 per cent are chronically ill; 12 per cent are physically ill as well as being mentally ill; 25 per cent are domiciliary; 16 per cent are welfare patients, who could be discharged but have nowhere to go. This difference leads to a greater utilization of drug therapies, rehabilitative programs, and long-term care programs for chronic patients, and to a lesser utilization of psychotherapy.

Services

The inpatient services of the Ontario Hospitals often consist of 1,000 or more beds. Queen Street, Kingston, Whitby all have 1,000 or more such beds. St. Thomas has almost 1,500. These do not include residential units for chronic and senile patients. There is a fairly typical treatment pattern. A newly admitted patient receives intensive treatment and attention for the first three months. If no progress is made during that time, the amount of attention he receives gradually falls off, until after six months he will usually be transferred to a chronic ward to await either spontaneous remission or the lapse into permanent debility. Nevertheless, the average stay in hospital for new admissions is less than three months, and 85 per cent of new admissions are discharged in less than two months at an Ontario Hospital such as the one at Kingston. This means that the great number of domiciliary, welfare and chronic patients are a carry-over from the period prior to the psychotropic drugs, which have been effective in controlling psychoses. Unfortunately, it also means that the rate of readmissions is increasing, because the drug therapies appear to control rather than cure these illnesses.

Ontario Hospitals also operate outpatient clinics, mobile clinics, and rehabilitation services. Some of the hospitals, such as Queen Street and Kingston, are teaching hospitals, providing residences in psychiatry and practicum settings for psychologists and social workers. Others, such as Whitby, provide practicum settings for specific disciplines — in this case, psychology.

Professional Policies

In general the professional policies of the Ontario Hospitals are similar to the policies of the general hospitals. The major exception is the greater extent to which the non-medical professions, especially psychology, are able to contribute to ward treatment programs and ward management in the Ontario Hospitals. One example is the Ontario Hospital, Kingston, another is Lakeshore Hospital, yet another is the work of the psychology department at the Ontario Hospital, Hamilton. A notable feature of the work of this department is the program of supervising nurses in group psychotherapy. The psychology department at Whitby Hospital is being greatly expanded and strengthened through its affiliation with York University.

Because the Ontario Hospitals must cope with the problem of rehabilitating patients who, while able to return to society, will probably continue to suffer impairment, they need — as the general hospitals do not — a staff of occupational therapists and industrial rehabilitation officers. These positions are scarcely less difficult to fill than positions for psychiatrists, psychologists, social workers and nurses. The one exception is St. Thomas, which has had the greatest difficulty in securing professional staff but has been able to mobilize an industrial rehabilitation program and a sheltered workshop for chronic patients who have no prospect of returning to society.

Special Care Homes

It was frequently stressed in field interviews that there is a great need for special care homes for patients who are able to leave hospital, but who are unable to support themselves in society and have no one to provide for them.

The major need is in the area of post-hospitalization care. At present the maximum rate of pay for such boarding homes is three dollars per day. This amount is not attracting any serious response. Considering the fact that care of a patient in hospital costs from eight to eleven dollars per day, an increase in the amount of money paid for after care in a private home is reasonable.

It would probably be desirable to create a group of small foster homes. In Saskatchewan there is a range of rates for domiciliary, part nursing and full nursing care homes. At present about 10 per cent of the people in the hospital setting could be placed directly in a domiciliary care setting.

This development could help, but would not entirely solve, the problem of providing proper care for patients who return after treatment to communities remote from the hospital. Neither would it solve the problem of coordinating community services, because of overlapping welfare, public health and municipal boundaries, or because of the lack of adequate numbers of qualified private practitioners to whom patients can be referred for post-hospital supervision.

Staffing Problems

The shortage of adequate numbers of professional staff affects almost all Ontario Hospitals, which tend to have greater difficulty than the general hospitals in securing the required professionals. The hospitals in Toronto are among the best staffed. The hospital with the most severe shortage is St. Thomas, which has 1,491 patients in what is lightly referred to as active treatment and 245 patients in residential units. To treat, rehabilitate and care for these patients the hospital has a staff of only seven psychiatrists, one of whom is engaged in full-time administration and another of whom is engaged in both administration and the mental health clinic. There are four psychologists on staff, but one of these works in the outpatient department. The hospital does, however, have forty occupational therapists, occupational therapy assistants, and rehabilitation officers. There are twenty-seven nurses in supervisory positions; twenty registered nurses; ten psychiatric nurses; thirty-five senior nurse's aides; 204 nurse's aides; twenty-five attendant supervisors; twenty-five attendants, group 3; and 190 attendants, groups 1 and 2.

By comparison, Whitby is well placed with 1,000 patients in active treatment and 400 in residential units. It has a professional staff of eight psychiatrists and three certificate eligible psychiatrists, supported by a number of psychiatrists on a consultant basis; four psychologists plus one psychology consultant and four psychometricians; sixteen social workers including some nurses who are working as social workers in the supervision of boarding homes; and four Masters of Social Work and three social work assistants. The nursing staff at Whitby consists of twenty nurse supervisors; twenty-four general R.N.'s; sixteen graduate nurses of whom two are psychiatric nurses; thirty-one part-time nurses; seventeen R.N.A.'s; 200 aides; 200 attendants; and twelve instructors. There are plans to add twenty-one or twenty-two new nurses to the staff. Moreover, an interesting fact (which probably applies to the other hospitals, but which was not mentioned by them) is that overtime work given by the aides and attendants on staff was the equivalent of sixty-four extra staff members. On the other side, however, the outlook of the staff at the lowest level is to make the fullest use of sick time and leave; consequently, the hospital loses the equivalent of twenty staff per year through absenteeism.

The problem of attracting professional staff to a smaller hospital, which does not have the overwhelming problems of scale to cope with that hospitals such as St. Thomas has, is illustrated by the Ontario Hospital, Goderich. This is a small hospital of 300 beds serving the semi-rural area of Huron and Perth. It was opened within the last three years, and comprises an acute admission centre and an alcoholic unit. There is also a day hospital and an outpatient department. The admission rate runs at thirty to thirty-five per month. The hospital is in the process of developing community health services and a child psychiatric unit. It is acutely short of psychiatrists and psychologists. The staff is comprised of the superintendent, who is doing some clinical work, plus two full-time psychiatrists

and one part-time. None of these is a formally qualified psychiatrist, in the sense that to date none has met Ontario's requirements. There is one psychologist from London, and one member of the University of Western Ontario psychology department who consults on a part-time basis. Of the three social workers only one is fully qualified. It is felt that in addition to the superintendent, the hospital needs three senior psychiatrists: one to take charge of the children's unit, one for the alcoholic treatment centre, and one for the chronic ward. In addition, two junior psychiatrists are necessary.

There are fourteen registered nurses on full-time staff; two graduate nurses; two psychiatric nurses, both of whom were trained in Jamaica; fifty attendants and fifty-three aides. There are also twelve university students from the area, who are working as paid summer employees in the occupational therapy and industrial therapy units with the patients. It is claimed that the number of these students that return each summer indicates that they find the work rewarding.

The main problem faced by the hospital is the difficulty in obtaining staff in almost all categories because of its geographical isolation. In the opinion of its director the only hope for an outlying hospital of this sort in attracting needed professionals is to become affiliated with a university, in this case with the University of Western Ontario. It is felt also that the refusal on the part of the government to recognize graduates of other provinces or countries is an impediment to staff recruitment; and it is suggested that graduates of accredited medical schools be recognized after a one-year probationary period within the province.

The current shortages in the different professions in the province have been detailed by Raymond Berry. It is not easy to foresee a time when most of the Ontario Hospitals will have solved their professional staffing problems.

Special Problems

The Hospital and the Community

The Ontario Hospitals are many things. They provide care to adolescents and to the senile, to harmless eccentrics and to the homicidal, to the prosperous and to paupers, to those who will never return to the community and to those on the point of return. In some instances they are functioning as day and night care centres. Some are offering outpatient facilities to the surrounding districts, and some have mobile mental health clinics which visit the outlying areas in the catchment area of the hospital. Programs and problems naturally differ considerably from one location to another.

The geographical locations of the hospitals themselves seem to be the greatest factors in influencing the quality and nature of the service provided. The problems faced by the St. Thomas Ontario Hospital are illustrative of the vicious circle in which many of these hospitals find themselves. The hospital is not located in a

major urban centre; it is not affiliated with any university in any department; it has a huge patient population from a vast catchment area. Thus, it is impossible to attract the staff to inaugurate exciting treatment programs that will attract yet more high quality personnel. Instead, treatment problems overwhelm a staff that is insufficient to cope with them, with the result that the prospect of working in the hospital is not attractive to brilliant young psychiatrists and psychologists.

Nevertheless, it is very important that our hospital system should solve the problem of attracting sufficient numbers of well-trained professionals to hospitals in rural communities and small cities. It is beneficial for a patient to be treated within his community. Being "sent away" not only carries a stigma which may impair the patient's social and work life when he is discharged; but it also means that he is often cut off from his family and friends, and from all the resources of the community that will be essential to his successful recovery. Moreover, it is difficult for the hospital to provide adequate continuing care upon his release if he lives many miles from the hospital.

An obvious solution to the problem seems to be simply to strengthen and expand the growth of psychiatric units in general hospitals. But for two reasons this is not a viable solution. First, the general hospitals are not "many things". Their treatment policies are a natural outgrowth of their basic medical purposes. They will remain ill-suited for the care of geriatric patients, and for the treatment of treatment and care programs essential to comprehensive community-based disorders. They are not equipped to achieve the necessary range and flexibility of treatment and care programs essential to comprehensive community-based mental health hospital services. Second, the general hospitals are essentially medical institutions. They are quite properly dominated by the medical profession. But mental health hospital resources require essential contributions from the different mental health professions. Despite some notable exceptions, it is very unlikely that the full and proper utilization of all these resources could be developed within the general hospital environment.

Consequently, what is needed are comprehensive community mental health centres that can provide high quality services for the entire spectrum from the care of geriatric, senile patients, to the treatment of emotionally disturbed children, to family therapy in an outpatient clinic. These centres should have definite, manageable catchment areas; they should be deeply rooted in the community; they should be large enough to justify a full complement of professional staff of all kinds but small enough that bed-ridden, ward-confined patients would represent the smallest part of their work (forty to 100 beds at most); they should replace the psychiatric units in general hospitals, while providing to the general hospitals the specialized services needed by patients who are receiving medical treatment in the hospital but suffering from a psychiatric complication as well.

The Community Mental Health Centre and the Department of Health

For a number of reasons the proposed community mental health centres should not come under the direct administrative control and operation of the Department of Health.

First, the centres' autonomy would reverse the undesirable trend towards bureaucratic centralization. In Ontario our mental hospital system functions subject to all the disadvantages of scale. If one is manufacturing automobiles, then the centralization of as much of the process as possible in a vast plant with a high volume of output will produce economies. If one is caring for, treating, and rehabilitating the mentally ill in hospitals, then large institutions provide economies of scale in everything that is more or less irrelevant, and cause inefficiency in what is essential to the treatment of the patient. A small community mental hospital providing a full range of mental health services to the community, known and perceived more realistically by the community, would probably be more economical in the long run because it could undertake rehabilitation of permanently disabled patients more effectively and less expensively through the imaginative use of community resources.

Bureaucracies themselves tend, not by intention but by function, to produce anonymity, alienation and irresponsibility, all of which are psychiatrically undesirable qualities in any system, let alone in one designed to promote mental health.

Autonomous community mental health centres would protect the system from any shocks and would insulate each hospital from the harmful publicity which might be associated with another.

It would also doubtless allow greater experimentation in organization, staffing and treatment techniques than is presently possible because of provincial regulation and job classifications.

The hospitals would be able to decide their own building and expense priorities, depending upon their own estimations of the needs of the hospital for treatment and care. They could also design their own buildings, confident in the realization that they could not do worse than has already been done. There has been substantial criticism of the speed and order of priorities set by the Department of Public Works, which do not seem to relate to the needs of the hospitals.

Against this proposal there is the objection that communities will not take up their responsibilities for mental health services but will insist on some alien force such as a government department doing it for them. To be sure, the public needs enlightenment. The dismal record of frustration encountered by health officers and other concerned parties who have tried to get action from County Councils to improve local mental health services is evidence of a widespread wish to

alienate mental health problems from the community. But this attitude will never change if it is not challenged. It may be itself a derivative of psychopathology in local officials. The current system does not challenge it. It cooperates with it. In fact, community psychiatry has taught us that these attitudes are among the very things that must be subjected to "psychiatric treatment". What is needed is a community mental health centre based on a philosophy that takes into account these negative community attitudes towards its own existence.

These centres could be operated by boards made up of professional staff and members of the community. The role of the Department of Health could be readjusted to providing grants on a reputable basis, providing basic overall planning and guidelines, stimulating growth in training, services and research where needed, and maintaining standards.

The Ontario Hospitals could gradually wither away. No one would mourn their passing. Similarly, psychiatric units of general hospitals could be converted to other medical uses as the population increases without loss to the taxpayer. Possibly teams of capable mental health professionals could be attracted to such centres, because of the diverse and varied range of services in which they would or could be involved.

A Model for Community Mental Health Centres

The United States has already embarked on a vast community mental health centre development. It was started under the provisions of the Kennedy Legislation on mental health which was incorporated in the National Community Mental Health Centre and Mental Retardation Act, known as Public Law 88-64. This law was passed by Congress in 1966. Although initially it provided funds only for buildings, its provisions were extended in the following year to provide funding for the professional and subprofessional staff needed. Under the terms of the Act, in order to qualify for federal funding a service unit must serve a specific catchment area with a population of 75,000-200,000 persons. Furthermore, it must provide five specific services to the catchment area: an outpatient clinic (mental hygiene clinic); an inpatient service; a day care service; a research program to investigate mental health problems in the catchment area; and a teaching and training program to develop professional and subprofessional mental health resources in the area.

One of the mental health centres established under the provisions of this law is Service Three, in New Haven, Connecticut. Service Three is still at an experimental stage. At the time at which it was visited and its director, Max Pepper, was interviewed, Service Three had been in operation for a year and a half.

Service Three has in operation an outpatient clinic which provides classical psychiatric care. This service was the first to be established. It has expanded rapidly in response to community need.

In addition to the outpatient service there is an inpatient service which provides both complete bed care and also overnight or day care, depending on the treatment needs and socio-economic situation of the patient. The inpatient service consists at the present time of twenty-two beds. It was deliberately decided to leave the development of the inpatient facility to the end in order to test out the extent to which such a service represents a necessity for a psychiatric unit, and the extent to which it represents a habit of mind, practice and institutional organization within psychiatry. The comparison here can profitably be made with the Saskatchewan plan, which set about the development of its inpatient service in an orthodox manner, only to discover that too many beds had been provided and that the facilities that had been developed and constructed were not actually needed. The inpatient service provides one bed every 3.5 thousand population in the catchment area. The idea behind the timetable for developing the unit was that no stone should be left unturned in trying to find ways and means of locating or developing suitable homes in the community itself for patients, even those who suffer from chronic mental illness or from mental retardation and brain damage with mental dysfunctioning. It is partly in order to experiment further in this direction that the director is anxious to have patients (from the catchment area) who are now resident in wards of state hospitals returned to his unit at an early date. Thus, Service Three will provide *every* kind of mental health service to its catchment area, including the care of geriatric patients.

It is Dr. Pepper's view, and his hope, that when the scope of the service in terms of the total numbers of patients in hospital beds is kept small, there is a much better chance of their problems receiving the kind of individual attention that will maximize their chances of recovery or rehabilitation. Also, when the catchment area is relatively small, there is a better opportunity of establishing close relations with it, and especially with the families of the hospitalized patients and with the community agencies that can facilitate well-supervised rehabilitation. Instead of a schizophrenic being permanently removed from his community of origin to a remote mental hospital where he becomes one of many populating large wards, he is hospitalized in the community in the care of a group of professionals who can be made more easily aware of any possibilities there are for his rehabilitation. In such a system there ceases to be a need for large mental hospitals for chronic cases or for psychiatric wards in general hospitals. Nor is there the same need for elaborate rehabilitation programs; for it is expected that groups within the community itself will take up this responsibility, with the guidance and assistance of a relatively small staff of occupational therapists.

Indeed, a number of specific steps have been taken to relate the Service Three Unit effectively to the community formed by its catchment area.

Early in the history of the unit, indeed during the summer prior to its establishment, a group of student volunteers were asked to study the area. These volunteers were selected from a group of students who, hearing about the develop-

ment of a community psychiatry program in New Haven, made application to the director to become involved in the work of the unit. These students were asked to undertake a study of the catchment area and its population with a view to getting more information and insight into the beliefs, attitudes, aspirations, social conditions, and behaviour patterns of its population. No a priori plan of research was imposed on these student volunteers; they were invited instead to undertake whatever research program their own individual interests and abilities led them to. Consequently, each student undertook a rather different kind of study, using his own approach. The reports of their summer studies have helped the staff of the unit to understand the community they are serving, and they have also made the unit and its services better known to the community.

Some of the students have returned to work as psychiatric aides in Dr. Pepper's unit or in other units of the Connecticut Mental Health Center in New Haven, as a result of their summer experience. Consequently, it has worked also as a recruitment method.

The existence of the unit — and, in particular, the manner in which it has related itself to its community — has had a dramatic effect on the number of people seeking outpatient psychiatric services. Prior to 1966 when Service Three first went into operation, the population of the catchment area had available to it the outpatient services of the Connecticut Mental Health Centre in New Haven, which it shared with any other residents of the New Haven area. And prior to 1966 the largest number of persons from the catchment area seeking psychiatric help in the outpatient clinic of the Connecticut Mental Health Centre, New Haven, was 190 to 200; the average number per annum was approximately 160. In its first year of operation, Service Three treated 325 patients in its outpatient clinic. As we noted earlier, in 1967 it was predicted that it would treat approximately 600 patients, based on the fact that by July 1967 about 300 patients had sought help. All of these patients were found to be in need of psychiatric help. They received, in the outpatient clinic, classical psychiatric therapy; that is to say, they received psychotherapy in varying degrees of intensity over various periods of time, ranging from one session per week for several weeks, to three sessions per week for several months and up to two years. Psychotherapy may be given either on an individual or on a group basis, depending on the indications of the illness itself. Psychotherapy is sometimes supplemented by drug therapy. Electroconvulsive therapy is used very rarely, and labotomy and insulin coma therapy are not used at all.

It is obvious that there is an escalating manpower problem in the outpatient clinic of Service Three, as the population of the area becomes increasingly aware of the nature of the resources available to those in the population who suffer from psychiatric illness. This problem is being met in part through the training of a group of non-professional mental health workers to do psychotherapy (both individual and group) under supervision. The workers so trained are designated

officially as psychiatric aides and are paid by the state as civil servants according to the schedule of pay applicable to this grade of worker in the State Department of Mental Health. The psychiatric aides are recruited from the catchment area itself, for the particular purpose of providing additional employment opportunities for the population of the area, as well as to further educate the local population through their involvement with the work of the Service Three Unit.

In addition to the training program of non-professional mental health workers, two special projects of an experimental nature are of particular interest. The first is a community mental health program. On one morning of every week, local public health nurses, teachers, general practitioners, probation officers, child welfare agency workers, police, and politicians come to the clinic to receive instruction and to observe the work of the clinic. Their purpose is to explore ways in which they can improve the quality of their own work in relation to individuals suffering from mental illness with whom they come in contact. It is not the aim of this program to train the individuals concerned as therapists. It is rather to make them more adequate in their relations with the mentally ill in their everyday work and neighbourhood environment, so that they can contribute to the creation of a social environment in which the mentally disadvantaged person will be able to function more successfully and will receive maximum benefits. Dr. Pepper has premised this program on the assumption that it is highly undesirable to have a social environment for a patient which is undoing the gains that he is able to make through his therapeutic relationship with the clinic. Through this program Dr. Pepper also hopes to have some impact on the levels of mental health in the community at large, by improving the quality of interpersonal interaction wherever possible.

The second special project is the work of Service Three in inaugurating new forms of cooperation between both agencies and specific individuals in the catchment area, and the clinic. The following example may be cited. A local clergyman came to the clinic and offered to undertake a group follow-up program whereby patients who are discharged from the hospital could come regularly as a group to see the clergyman for assistance in their adjustment to life outside the hospital. The clergyman works under the supervision of, and in cooperation with, a psychiatrist. The underlying concept of this program is to explore the availability and utilization of the human resources of the community, so as to expand psychiatric services through education and training, partly of a formal nature and partly of an informal nature. Service Three is still in an experimental stage, and Dr. Pepper adopts the principle that a variety of new devices, plans and instrumentalities should be explored, tested out and discarded when they are not effective, but strengthened and expanded when they work.

It must be understood that Service Three has the advantage of being associated with a great university. It is not easy to imagine something similar taking place in Sault Ste. Marie, Timmins or Sarnia. Nevertheless, it is a model

of what is desirable, and it demonstrates a range of new clinical resources in mental health through imaginative organization and utilization of professional, subprofessional, community and private resources.

By refusing to accept the idea that the severely mentally ill should be more or less permanently hidden from the community, and by insisting instead that the community continue to accept the mentally ill person as belonging to it, Service Three is trying to enlist as many natural community resources as possible in prevention and rehabilitation. It is hoped that the program will eliminate the necessity of vast artificial institutions with groups of professional and semi-professional personnel performing services, some of which are made necessary only by the institutional arrangements themselves.¹¹

The current frame of mind of mental health professionals in Ontario as reflected in field interviews is one of general opposition to the Ontario Hospital system. There is also a great deal of uncertainty and difference of opinion about what should replace it. The proposition is advanced here that a number of pilot projects in the design and operation of comprehensive community mental health centres should be undertaken: one in a large metropolitan area, one in a small city-rural area, and one in a town-rural area. The transition to community mental health centres might best be envisaged as a long-term objective achieved through a series of transitions over a period of time.

Coordination of Community Resources

Almost everywhere in the province the effects of the centralization and bureaucratization of various services into separate domains is presenting difficulties in the achievement of adequate coordination and utilization of community resources. An additional difficulty is the overlapping jurisdictional boundaries of municipal and county political units, welfare, educational, public health, hospital and ADARF district units. The absence of common jurisdictional boundaries impedes close cooperation between the various agencies which are supposed to be responsible for many facets of the patient's experiences before, during, and after his treatment in hospital.

Community mental health centres could serve as coordinates of the various public services affecting the mental health of the community. In the meantime, every effort should be made to remove these barriers to more effective utilization of community resources.

Internal Organization of the Hospital Administration

Certain steps can be taken to improve the functioning of the existing Ontario Hospitals. The first, a step which has been taken already, is the introduction

¹¹Field interview with Max Pepper, M.D., Director, Service Three, Community Mental Health Centre, New Haven, Connecticut.

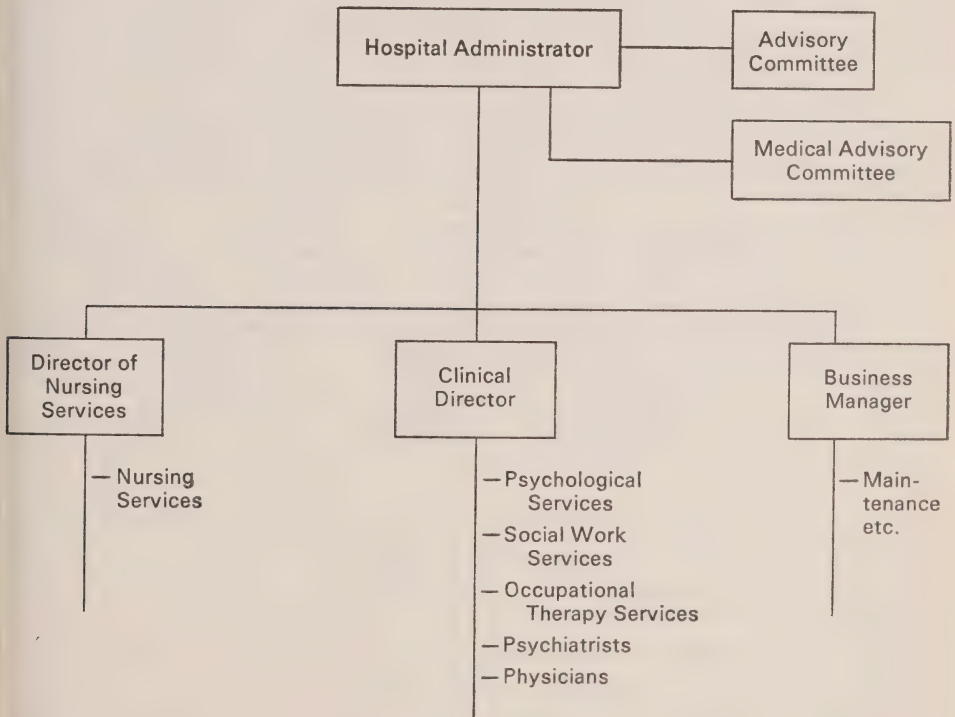
of lay hospital administrators to relieve psychiatrists of the burden of administrative work, for which most are not specifically trained, and to release them for therapeutic work with patients.

There are other aspects of the administrative reorganization of the hospitals that require comment in this connection. The reformed administrative structure could assume the form shown in Figure 12.1.

This structure has certain basic weaknesses. For one thing, it places an administrator who cannot possibly have a deep understanding of the work of the hospital in a position of authority he cannot properly exercise. Therefore the hospital administrator should be the chief business manager, working under the direction of the professionals who alone can set policies and priorities for the hospital.

In this structure psychological and social work services are not given the autonomy that nursing services receive. In the light of the facts established earlier in this report, that psychologists find they can work most satisfactorily with

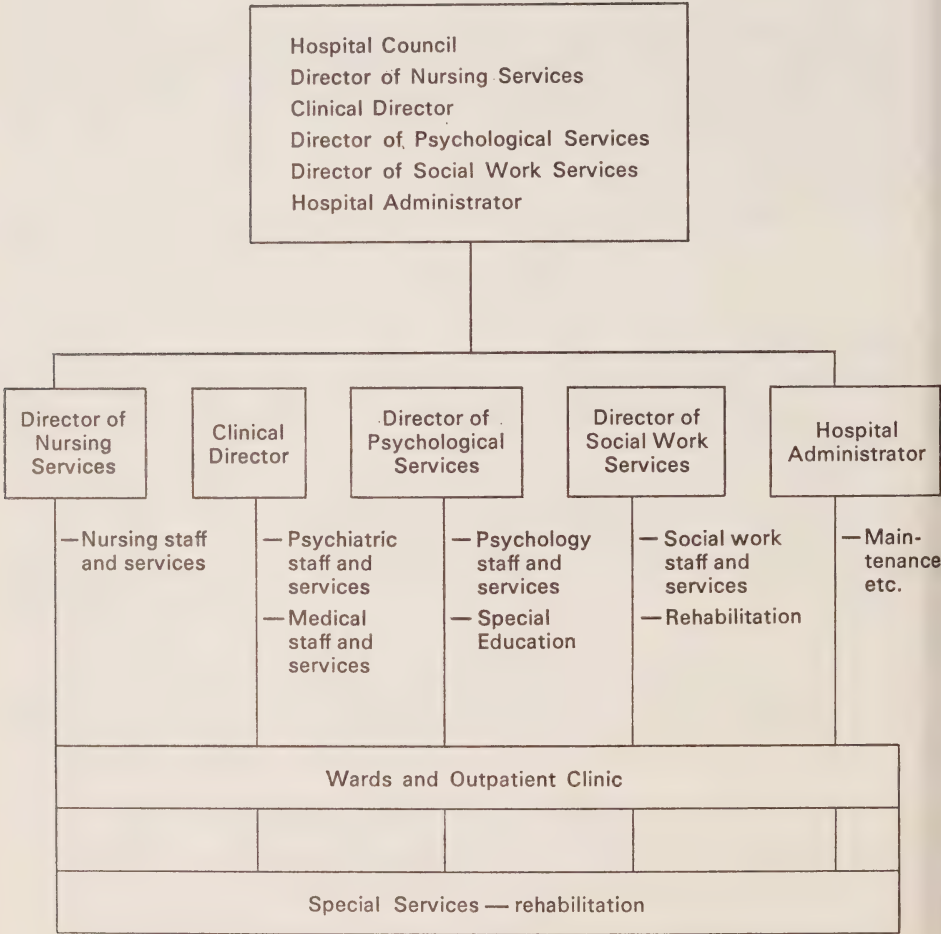
Figure 12.1



others of their own profession and that top rank clinical psychologists are not attracted to working in a system in which their professional autonomy is granted to them (if at all) by doctors, it would be a further improvement to have a structure in which the chief of psychological services is on a par with the clinical director. In this structure the clinical director would be responsible for psychiatric and medical services; the directors of social work and psychological services would be responsible for their respective areas.

An alternative model adjusted to accommodate these criticisms is presented in Figure 12.2.

Figure 12.2



This organization of decision-making within the hospital has the advantage of applying to the operation of the hospital itself the team concept that is general policy for ward services. It provides for coordinated policy-making at the top and for services at the ward level.

There are obstacles in the way of implementing this concept. At present there are not substantial numbers of gifted, experienced clinical psychologists to assume the responsibilities of a Director of Psychological Services. However, unless the hospitals demonstrate their willingness to be adaptable on these issues of professional autonomy, it is unlikely that there will ever be adequate numbers of top level psychologists in these services; and no one disputes the fact that they are needed.

Hospitals and Professional Responsibility

Connected with the question of the proper authority structure in hospitals is the question of legal responsibility.

The utilization of available professional personnel could be improved, if the system of legal responsibility were changed within the treatment centres so as to recognize existing practices and to have the safeguards already discussed built into the service relationships among physicians, psychiatrists, psychologists and social workers. This change would have the benefit of removing the entire burden of legal responsibility from the doctor, who must now unfairly assume it in all cases and circumstances. Also it would improve the manpower situation by attracting more bright, well-motivated people into hospital service by giving them the kind of responsibility for their work that any capable professional person wants to have.

It is apparent that the comprehensive community mental health centre is a better institutional house for these reforms, because here the role of medicine would not *have* to dominate as it does in general hospitals and to a lesser extent in Ontario Hospitals. But even in regard to the existing Ontario Hospitals, as was pointed out before, they are heterogeneous organizations doing many things from custodial care to active treatment, to rehabilitation, to day care. In many cases, they are not trying to "cure" mental illness, but are trying to resocialize people so that they can re-enter the community. This is the essential purpose of the ward democracy program in Ward 4A at Queen Street, of the industrial therapy programs in most hospitals, and of the milieu therapy program at the Clarke Institute. In the narrow sense, this is not really a medical problem, and it is only as a result of the present definitions of legal responsibility that a doctor must be head of the treatment team. It is unreasonable to expect a medical doctor to take the responsibility for the behaviour therapy performed by a psychologist, when it is only the psychologist who is competent to design the therapy and evaluate the results of it.

To the extent that the Ontario Hospitals are engaged in the process of the relief of distress, a doctor should be in charge of the program. But to the extent that they are involved in remotivation, in socialization, in teaching people how to learn and how to cope with reality, there is no valid reason why a psychologist, a social worker, or an occupational therapist should not take charge of the treatment of a particular patient. A change of name from "hospital" to "treatment centre" or "rehabilitation centre" probably would be appropriate. Other professions are not justified in saying that the medical model never applies to mental illness; in the same way traditional psychiatrists are mistaken in saying that it always applies. The truth is that both models apply, and it is the proper course to recognize in law what is taking place in practice.

Rehabilitation and Special Care Homes

In whatever long-term direction the province's mental hospitals may evolve, two steps should be taken to reduce the problems with which existing mental hospitals must cope by returning to society those chronic patients who are able to live outside the hospital.

The Ontario Hospitals are required at the present time to provide care for many long-stay schizophrenic patients who are essentially untreatable in terms of bringing about any basic improvements by medical and other therapeutic interventions. Some of these patients, however, could be rehabilitated to the extent that they could be gainfully employed in carefully selected jobs, and could live outside the hospital with their families, in adoptive homes, or in special group homes. The substantial reduction of the number of these patients in the Ontario Hospitals would be likely to have a beneficial effect on the general atmosphere of the hospitals and thus make them more attractive work settings for highly skilled professionals.

It has been estimated that 23 per cent of the long-stay schizophrenic men in the mental hospitals of England and Wales could be expected to be satisfactorily settled in open employment one year after completing a well-designed industrial rehabilitation program. Another 22 per cent might be satisfactorily settled in special closed or sheltered workshops.¹² The success of the industrial therapy program derives from its ability, not to basically modify the illness itself, but to counteract the secondary maladjustments to society and living that derive from hospitalization. Consequently, with provisions for adequate diagnostic procedures to select suitable patients for industrial rehabilitation, and with general planning and supervision of the rehabilitation program by professionals, the rehabilitation program can itself be run by subprofessional personnel. This subprofessional staff could very well receive a job classification within the general category of

¹²J. K. Wing, D. H. Bennet, John Denham, *The Industrial Rehabilitation of Long-Stay Schizophrenic Patients*, Medical Research Council Memorandum No. 42, London, 1964, p. 20.

mental health workers. The special orientation towards the problems of chronic mental patients in a rehabilitation program could be made available by community colleges, if they also were staffed to undertake the academic instruction of other types of mental health workers and nurses.

The government could increase its aid to the homes for special care programs and thus encourage more families to provide homes for patients who will not benefit from further active hospital treatment, but who are capable of living outside the hospital.

Conclusion

In conclusion, the importance of establishing comprehensive community mental health centres as part of a forward-looking, constructive social policy must be stressed. An incidental, but by no means negligible, social benefit to be derived from the creation of a system of independent community-operated mental health centres would be the decentralization of institutional structures in the province. Under the pressure of public demand for improved services and with the assistance of modern science and technology, it would be possible for the province to drift into the establishment of vast, bureaucratic, centrally controlled institutional structures which are dehumanized and dehumanizing, and which have less and less relationship to the ongoing life of our communities. In the field of mental health it would be all too easy to create antiseptic hospitals to which the mentally ill could be removed, sedated and largely forgotten by the communities from which they have come but which should be taking a continuing interest in, and some responsibility for, their well-being. As mental illness becomes better understood, new generations will be better prepared to assume more responsibilities more successfully for the long-term care in the community of persons who have had severe mental illnesses. The long-term development of our hospital system should be premised on this more hopeful outlook; it should not be structured and should not function in a way that will inhibit this social growth.

It follows from this position that, although the psychiatric wards now established and being established in general hospitals represent an improvement in the province's hospital services to the mentally ill, they should be seen as an interim solution. Meanwhile a better system should be tested and evolved utilizing the concept of community mental health centres capable of providing the whole range of mental health services needed by communities.

Chapter 13 Services for Emotionally Disturbed Children

Because of the shortage of hospital and outpatient services for emotionally disturbed children and adolescents, and the controversy that has often surrounded such services as have been available, they deserve some special attention. The major issue is the shortage of these facilities themselves. Related issues are legislation and accrediting procedures for the maintenance of standards; professional and subprofessional staff requirements and treatment policies; financing research; and the location and nature of facilities. The following discussion is divided into inpatient facilities and outpatient facilities.

Inpatient Facilities

Shortage of Facilities

The Ontario Hospitals are not well suited for the treatment of emotionally disturbed children. These children for the most part suffer from problems of personality development which produce disturbances in their relations with other persons and in their behaviour. Ego capacities such as speech, thinking, learning and so on also suffer impairment of growth. Relatively few suffer from psychoses, although this severe form of illness occurs in children, and good institutions are needed for them. It is not clear that Ontario Hospitals provide the best environments for the treatment of adults, they are certainly inadequate for children. Indeed, few children suffering from emotional disorders occupy beds in Ontario Hospitals. Most of the children in care in institutions operated by the Department of Health suffer from organic mental deficiency.

According to the Ontario Department of Health figures for 1965 the patient population in Ontario Hospitals for that year consisted of 2,542 patients under fifteen years of age; 2,963 aged fifteen; and 17,749 patients of all ages.¹ In order to interpret the significance of these figures however, it is necessary to note the statistics given in Table 13.1.

As the table shows, although there were 561 children under fifteen years of age admitted to Ontario Hospitals in 1965, only twenty-eight suffered from psychosis and ten from neurosis. The other 523 were admitted for various organic disorders.

¹See 99th Annual Report, Mental Health Division of the Department of Health, Ontario, 1965, Table VI.

TABLE 13.1
First Admission by Diagnosis and Age Group

Diagnosis	Age Group		Total
	0-14	15-24	
G.P.I., ¹ Syphilis of C.N.S. ²	—	—	6
Schizophrenic disorders	22	259	1,118
Manic-depressive	—	17	229
Involucional melancholia	—	—	157
Paranoia	—	1	81
Senile psychosis	—	—	389
Alcoholic psychosis	—	3	177
Epileptic psychosis	—	7	22
Psychosis with mental deficiency	4	75	55
All other psychosis	2	28	342
Total with psychosis	28	330	3,095
Psychoneurotic disorders	10	235	1,116
Alcoholism with psychosis	—	25	690
Mental deficiency without psychosis	393	151	633
Epilepsy without psychosis	42	33	105
All other with psychosis	88	489	1,061
Total	533	933	3,655
Grand Total	561	1,263	6,750

¹General paralysis of the insane.

²Central nervous system.

SOURCE: 99th Annual Report, Mental Health Division of the Department of Health, Ontario, 1965, Table XII.

Also, of the thirty-eight patients admitted to Ontario Hospitals with emotional disturbances, it must be realized that a good proportion would have been admitted to Thistletown Hospital, which treats only children with emotional disturbances, or to the CPRI. Consequently, it is unlikely that any such child patients were located in other institutions; or if any, the number would be very small.

No additional Ontario Hospital services should be provided for emotionally disturbed children.

The Department of Health operates the Thistletown Hospital and Warrendale in the Toronto area, and the Children's Psychiatric Research Institute in London. The former treats emotionally disturbed children only; the latter treats mainly (approximately 75 per cent of their cases) children suffering from organic mental dysfunctioning with some services for emotionally disturbed children. Both institutions provide excellent services, but they could not be considered models for

further development. There is an overwhelming need for community-based services, and these institutions must serve large regions of the province. In 1966 CPRI provided residential treatment for approximately 400 children (it has 110 inpatient beds) under the age of twelve years drawn from southwestern Ontario. The Thistlethorn Hospital receives patients from all over the province. In 1966, it had sixty-four children in treatment, aged six to twelve. The essential difficulty is that the hospital's treatment policies are based on the recognition that in most cases the entire family of an emotionally disturbed child needs treatment, and in all cases well-planned and well-executed post-hospitalization follow-up is necessary. These policies cannot be carried out adequately when the families of the children live at great distances from the hospital. Geography influences the quality and outcome of treatment.

It might at first appear that the psychiatric wards of general hospitals might offer a convenient solution to the problems created by geography. But for a number of reasons it is not realistic to assume that general hospitals can make a very substantial contribution to the expansion of these services for children. Not many general hospitals now have services for emotionally disturbed children. For example, Victoria Hospital, London and Western Hospital, Toronto have adolescent services, but patients must be sixteen years of age or older. Furthermore, it is difficult to develop all the essential ancillary recreational, educational and social facilities needed for an adequate treatment environment for adolescents or children in a general hospital. General hospitals require constraints on the duration of stay. The usual limit is two months. Yet this period of time is not adequate for the treatment of severe disorders in children and adolescents. Consequently, these hospitals are not well suited to provide the kind and quality of residential treatment and care that is needed. They have a very important special role, however, in the treatment on a short-term basis of children who suffer from an associated physical health problem which requires hospital treatment itself, and in the provision of short-term emergency treatment.

Children's hospitals such as the Sick Children's Hospital in Toronto is an exception, because it is not a general hospital. But it is also an exception because it is the only one of its kind in Ontario. The hospital *could* provide comprehensive psychiatric treatment, but until very recently it has neglected this service completely. Psychiatric facilities are now recognized as the hospital's most pressing need. It has a plan for a twenty-bed inpatient unit which will give treatment of up to one month's duration for children from eleven to fifteen years of age. The limitations applying to other general hospital services will also apply to it.

The main burden for treatment has been carried by private residential units such as Browndale (formerly Brown Camps Incorporated), Craigwood, Earls-court, Lynwood Hall, Maryvale, Mme. Vanier, Mt. St. Josephs, Sunnyside, Boys Village, Hinks Memorial Clinic, and others. Of these the Hinks Memorial Clinic stands by itself, in that it is a small private psychiatric hospital specializing in

the treatment of children. It gives short-term treatment and care up to a maximum of one year for children aged twelve to sixteen. It can accommodate sixteen children. These institutions are providing the long-term, intensive treatment and care that is needed by severely disturbed children and by children with lesser disturbances but without adequate familial support. By far the largest single service is Browndale. Exact data are difficult to obtain; but if there are approximately 600 children in institutions of this type in Ontario, approximately one-third of them are in services provided by Browndale.

These facilities are not adequate to serve existing need. Mount St. Joseph's Children's Centre, Hamilton, offers places for sixteen patients. In 1966 it received applications for twenty children it could not accommodate. Sacred Heart Children's Village with places for forty boys turned down applications for one half of the forty-six applications for treatment made in 1966. Craigwood, near London, was able to take thirty-two of the fifty-eight children for whom applications were made. Sunnyside Children's Centre, Kingston, was able to accept twenty-three of thirty-three applications. This pattern is fairly consistent right across the province.

A study conducted by a research group at Boys Village provides some measure of the extent to which residential treatment services are in short supply in the Metropolitan Toronto area. The study was based on a sample of 130 children who were diagnosed by a psychiatrist, between October 1966 and November 1967, as emotionally disturbed and requiring institutional care and who were either temporary or permanent wards of Children's Aid. The intake agency was asked to report the degree of urgency involved in each case in terms of the amount of delay possible without serious risk of ill effects, and the amount of anticipated delay in receiving treatment. Tables 13.2 and 13.3 present the result.

Because a few of the questionnaires were not completed, eleven had to be rejected from the first table and fifteen from the second, thus causing a small numerical discrepancy. The basic fact, however, emerges quite clearly. There are more children of all ages in need of immediate residential care than there are facilities available for them. Sixty were deemed to be in need of immediate treatment; only forty-four children were expected to be able to receive it.

TABLE 13.2

Amount of Delay in Treatment Acceptable for a Sample of Emotionally Disturbed Children

Urgency of treatment	Age of child		
	9 or less	10-12	13 or older
Immediate treatment needed	17	28	15
3-month delay possible	42	4	9
Greater than 3-month delay possible	2	1	1

SOURCE: A. Grant, Study conducted by Boys Village, Downsview, Ontario, 1967.

TABLE 13.3
Amount of Delay in Treatment Anticipated for a Sample of Emotionally Disturbed Children

Anticipated delay in treatment	Age of child		
	9 or less	10-12	13 or older
No delay	12	14	18
3 months	44	10	6
More than 3 months	4	6	1

SOURCE: A. Grant, Study conducted by Boys Village, Downsview, Ontario, 1967.

This finding has been confirmed by our own field interviews and by the results of our questionnaire survey. Of the children who were not deemed to be in urgent need of immediate treatment, thirty-five were thought to require special interim care during their waiting period at the receiving centre, in specialized foster homes, or elsewhere.

The factors in the child's life leading to his referral to a Children's Aid Society include the parents' inability to control the child, their inability to provide general care for the child, parental rejection, the child's behaviour at school, and his behaviour at home and in the community. In this sample of children these factors were of approximately equal weight, with two exceptions: the parents' inability to provide general care for the child, which was somewhat more frequent a factor than the others; and behaviour problems at school, which was applicable as a reason for the referral only in a very small percentage of cases.²

It is of urgent importance that vigorous steps be taken to expand residential treatment resources in the province for emotionally disturbed children. The means for achieving this objective are not so clear. A suggestion will be made in the conclusion.

Legislation and Accrediting Procedures

Inpatient facilities for emotionally disturbed children are available in the following settings established under different statutes of Ontario:

- 1) Psychiatric hospitals
 - a) Children's mental hospitals (The Children's Mental Hospitals Act, 1960)
 - b) The Clarke Institute of Psychiatry (The Public Hospitals Act and the Ontario Mental Health Foundation Act, 1965-1966)
 - c) Ontario Hospitals (The Mental Hospitals Act and the Psychiatric Hospitals Act)
- 2) Psychiatric units of general hospitals (The Public Hospitals Act)

²I am grateful to Miss Alma Grant of Boys Village research staff for these data.

3) Private residential centres

- a) Children's institutions (The Children's Institutions Act, 1962-1963)
- b) Boarding homes (The Children's Boarding Homes Act)
- c) The C. M. Hinks Treatment Centre (The Community Mental Hospitals Act)

With the exception of children's institutions and boarding homes, all are essentially psychiatric facilities operating under statutes administered by the Minister of Health. ("Psychiatric facilities" are designated as such by the Mental Health Act and are listed in the Schedules to the Regulations made under that Act.) These statutes lay down specific regulations which govern the organization, standards, financing, and so on, of these facilities. Regulations for those facilities which offer services to children and adults have no specific reference to children, but it is understood that these regulations apply to them as well.

The Children's Institutions Act and the Children's Boarding Homes Act, by contrast, are administered by the Minister of Social and Family Services. Facilities established under their authority are not necessarily psychiatric facilities, although some may be approved and designated as such under the Mental Health Act.

Under the Children's Institutions Act, a "children's institution" is defined as "building or buildings maintained and operated by an approved (approved by the Lieutenant Governor in Council) corporation for children requiring sheltered, specialized or group care" The Act makes provision for:

- 1) Grants and subsidies to be available for the building and maintenance of such institutions.
- 2) The inspection of institutions and the accounts by provincial supervisors at least once a year.
- 3) Making regulations on educational classes for children, the establishment of an advisory board, the conduct of children and staff, admission and treatment, qualifications of staff, medical and ancillary services, residence, payments, costs, records, and the like.

There are three types of institutions approved under the Act:

- 1) Institutions under Schedule 2 are for children in need of board, lodging and care.
- 2) Institutions under Schedule 3 are for children with difficulties in adjusting to or benefiting from normal family relationships.
- 3) Institutions under Schedule 4 are for emotionally disturbed children.

The regulations prescribed under the Act require that there be a specialized program for the care and treatment of residents in institutions listed in Schedule

4. The regulations also govern the standards of buildings; meals and accommodation; fire protection, services — religious, recreational, rehabilitative and hobby-craft activities; minimal number of child care workers; medical and related services — such as dietary and nursing services, minimal annual medical examination for residents, and available psychological and psychiatric services for institutions listed under Schedule 4.

Institutions operating under this Act are eligible for provincial aid to cover the total cost of the construction of buildings or of additions to existing buildings to a maximum based upon the bed capacity of the new building or the addition, at the rate of \$5,000 per bed. An approved institution is also eligible for a subsidy amounting to 80 per cent of its operating costs.

Children's institutions may be established under the Children's Boarding Homes Act, which provides even fewer restrictions and less government control. The Act requires the compulsory registration with the Department of Social and Family Services of any boarding home which houses five or more children. The only restrictions placed upon these boarding homes are that they should keep a register of the children, and that they should not have more than the prescribed maximum number of children residing in the institution. Their registration is also subject to cancellation for reasons of poor sanitation and insufficient fire protection. Therefore, some boarding homes may have emotionally disturbed children under their care and yet have none or few of the professional services which are deemed to be necessary for the care of these children. Unlike institutions approved under the Children's Institutions Act, these boarding homes are not necessarily non-profitable and thus are not eligible for any provincial aid.

The Department of Health has made a study of this unsatisfactory situation and has published a White Paper on the accreditation of facilities for emotionally disturbed children. As a result, an Accreditation Board as well as standards and procedures for accreditation were set up in the spring of 1967. The function of the Accreditation Board is to determine whether or not facilities which seek financial assistance from the Public Treasury come under the Mental Health Act.³ If the Board determines that the Mental Health Act applies to the facility in question, it will be designated as a "psychiatric facility" and will be eligible for 100 per cent financial aid from the provincial government.

The Accreditation Board consists of seven members: a paediatrician, a psychiatrist, a psychologist, a social worker, an educationist, a nurse and a hospital administrator. Of these, three are government employees. Facilities applying for accreditation are surveyed by one of the two Survey Teams of the Board, and on the basis of their report the Board makes its decisions. The Board may decide

³Transcripts of Hearing, Department of Health, February 12, 1968, p. 76.

to give the applicant 1) full accreditation; 2) provisional accreditation, allowing the facility a limited time to set right any inadequacy; or 3) no accreditation.

The facility in question is judged according to a set of defined Standards for Accreditation of Facilities for the Care and Treatment of Children with Mental and Emotional Disorders. These can be summarized as follows:

1) Administration:

- a) The facility is to be administered by a legally and morally responsible body which will conform to the legislation under which the facility was established.
- b) There should be a director and a suitable qualified staff. There should also be services of a psychiatrist, a social worker and a clinical psychologist where such are available.
- c) Each child should have a physical examination within forty-eight hours of admission and thereafter at least once every year.
- d) There should be a clearly stated admitting policy.

2) Requirements relating to physical facilities.

3) Essential services:

- a) Program planning, to provide group activity and therapy; education and teaching facilities. Records of these programs should be kept.
- b) Dietary personnel.
- c) Records must be kept on every child.
- d) Medications must be prescribed by a qualified medical practitioner. An approved drug list must be kept and reviewed by a psychiatrist and a medical practitioner.
- e) Where a boarding out or a family care program are maintained by a central facility, these should be on an approved list kept by the facility, subject to regular inspection; and professional personnel should visit each home at least bi-monthly.
- f) Staff: the number of child care workers must conform to the pattern set down by legislation under which the facility was established; medical staff full or part time must be appointed with at least one psychiatrist and one paediatrician where available; minimum nursing care must be provided by public health nurses; psychology and social work services must be available and easily accessible.
- g) Follow-up services for discharged children.

It will be seen that the standards set out are of a very flexible nature. They have been drawn to cover a wide range of facilities, because the Committee for Accreditation does not wish to advocate any particular method of child care. These standards are intended for only those facilities which seek financial assistance. Application for accreditation is entirely voluntary.

At the time of writing a Bill was before the Ontario Legislature which would provide a law for the establishment of accredited residential treatment centres for emotionally disturbed children, both private and public. Some such legislation is necessary. It is too early to tell whether or not this legislation will serve to guarantee high standards of care and treatment. It appears to offer broad discretionary power to government officials, which is to be exercised "in the public interest"; but whether such discretionary power is itself in the public interest is a matter for debate. It will depend on how it is exercised and by whom. It should be exercised by qualified professionals who are experts in the field of child treatment. In any event, legislation itself cannot achieve high standards of treatment. The basic problem that has to be solved is the problem of professional development.

Professional and Subprofessional Requirements and Treatment Policies

Almost all of the facilities visited or contacted by questionnaire were experiencing staffing problems. The problem has two parts—professional and subprofessional—and the professional problem must be further subdivided into medical and non-medical. Institutions such as CPRI, Thistletown and the general hospitals tend to experience no difficulty in securing medical and psychiatric personnel, but they do have trouble in finding psychologists and social workers. They also find it difficult to maintain an adequate staff of child care workers, who form the backbone of the care resources.

The problem shifts when one considers the private residential centres. All or most of these centres (the Hinks Memorial Clinic is an exception) must satisfy themselves with psychiatric services on a consultation basis only, and most of them are in a similar situation with regard to psychological services. Most have full or part-time social workers, but Masters of Social Work are difficult to obtain. The most general shortage is child care workers. Almost all facilities were experiencing great difficulties in maintaining adequate care services and desirable patient-staff ratios because of the short supply of these personnel.

The institutions that have least difficulty in obtaining both sufficient numbers and highly qualified professional personnel are those that are affiliated with medical schools and university departments for the purpose of providing residency, practicum and field work training. Hospitals such as CPRI, Thistletown, the Clarke Institute, and the Hinks Memorial Clinic all enjoy this advantage. Institutions that do not enjoy this advantage have severe chronic problems in professional recruitment. Smaller institutions can manage on the basis of consultations, but their growth tends to be rigidly limited by the absence of expert part-time or full-time professional resources. Some institutions that did not provide training for psychiatrists and psychologists were able to do so for social workers. Most provided training settings for child care workers.

Most of the children in these treatment institutions do not require ongoing medical attention, and relatively few receive drugs as part of their treatment. The great majority suffer from character and behaviour disorders, and some from neurosis. Psychosis is least frequent. Consequently, psychological therapies dominate, including milieu therapy, individual and group psychotherapy, and counselling. It was frequently stressed in field interviews that in the treatment of children for whom ongoing physical and mental growth is most necessary, the ability to provide intelligent, healthy relationships and experiences appropriate to the arrested or regressed state of the child is essential. For this reason the quality of the day-to-day care and relationships provided by the child care workers is of first importance. Nevertheless, many children with severe illnesses will require the attention and treatment of highly trained experts (psychiatrists, psychologists or psychoanalysts). Those institutions that have them provide programs of psychotherapy according to the needs of individual patients.

The single most disturbing feature of the treatment policies of these various institutions was the way in which they reflected professional resources. Institutions that could not gain the services of professionals, except on a light consultative basis, based their treatment philosophies on the idea that milieu therapy is all important and self-sufficient; those that had professional resources for treatment purposes were able to adopt a broader concept of treatment, which attached due importance to the therapeutic intervention of trained professionals. Diagnosis was always performed by trained professionals. But there is an important problem here as well. How does the diagnosis become adequately translated into an effective treatment program unless the persons who make it are deeply and thoroughly involved in the treatment itself, at least on the basis of weekly observations of the patient and detailed consultations with the child care worker in charge of him? Institutions without adequate professional resources are likely to encounter difficulty in accomplishing this crucial adjustment of treatment to diagnosis.

Evidently milieu therapy occupies a place of great importance in the treatment program for emotionally disturbed children in residential settings. Milieu therapy is employed by all or almost all of the institutions studied. Whether milieu therapy is regarded as a form of treatment in itself, or rather as a care program in support of more specific treatment, the personnel who carry out the milieu therapy are child care workers. The utilization of child care workers in the best residential institutions is premised on two specific limitations: 1) they do not design the overall treatment program for the child; 2) they are barred from the practice of group or individual psychotherapy.

The implication of both these restrictions is that child care workers are best utilized in an institution in which their work can be planned and supervised by senior mental health professionals; and that these professionals will also be available for consultation in relation to specific problems that the child care

workers may encounter in carrying out their duties. These limitations being understood, there can be no question about the great importance of child care workers in the treatment programs of residential centres for emotionally disturbed children. There is ample evidence of a widely recognized need for more of these personnel who have received careful training for their work. It is also in the best interests of these services that child care workers should receive at least a part of their formal training in an institution which is independent of the centre in which they receive their practical training. The danger inherent in a completely in-service training program is that the child care worker will become familiar with only one approach to treatment — the one which is typical of the institution in which he has received his in-service training — resulting in a reduction of his adaptability to different treatment programs in different centres and a restriction on his employment mobility. Consequently, the development of well-designed curricula in child care work at community colleges and institutes of technology is desirable and should be encouraged.

Most of the residential treatment centres have a physician consultant, often a paediatrician, who can diagnose medical problems and prescribe required treatment and medication. Psychiatric units of general hospitals are available, of course, for children who have severe organic as well as mental health problems, and it is these patients that psychiatric wards in general hospitals are ideally suited to serve. However, the great majority of children suffering from severely disabling emotional disorders do not have major concomitant organic illnesses. As a result, there is relatively little medication prescribed in relation to the treatment centre may be safely restricted to that of a consultant available to deal with specific problems as they arise. Furthermore, the major forms of treatment for children are psychological in nature rather than organic or chemical. Consequently, there is relatively little medication prescribed in relation to the emotional disorders themselves. The prescription of such medication as is necessary is, however, a strictly medical function; and where the medication relates to a psychiatric disorder, it should be prescribed by a psychiatrist. As far as our studies were able to ascertain, this principle is followed by all residential treatment centres in Ontario.

It is generally the case that a psychiatrist is the chief of the services in a residential treatment centre, and acts as the head of a treatment team when the professional services are organized on the team principle. This situation arises out of the fact that the psychiatrist is usually the most broadly educated member of the staff and is able to take the most effective overview of the patient's needs and requirements, as well as plan the methods of treatment best designed to serve them. However, this role of psychiatry is also in part an accident of the traditions of mental health services in Ontario, and of the traditions of education and training in clinical psychology and psychiatric social work in Ontario. When one examines more closely the work of psychiatrists and clinical psychologists in these treatment centres, one finds considerable overlap in their roles *when one very*

specific condition has been fulfilled: whenever a clinical psychologist has had the requisite training in psychodiagnosis, in psychotherapy, in treatment planning, and in treatment supervision and review, he will be utilized on an equal footing with psychiatrists in all of these roles. Consequently, if one takes the view (and it would appear to be an altogether reasonable one) that medicine will never be able to train sufficient numbers of psychiatrists to meet the demand for services for psychodiagnosis and psychotherapy in these residential treatment centres, then what is most needed is major improvements in the scope and quality of training in clinical psychology in the specific areas of psychodiagnosis and psychotherapy. If clinical psychologists were trained to an equal level of competence in these areas with psychiatrists, then there would appear to be no objection in principle to a clinical psychologist's assuming full responsibility in such a setting for diagnosis, for treatment planning, and for specialized therapy, provided that he can work in close collaboration with a physician who is competent to diagnose and treat any related organic problems.

The specific role of the psychiatric social worker also emerges quite clearly from the day-to-day practice of these residential centres. In the best of them, the psychiatric social worker undertakes mental health counselling with the family of a patient, to bring about whatever changes are necessary in the psychodynamics of the family so that the patient may be returned to it without danger of a recurrence of his illness. This is a function for which social work is, by tradition, admirably suited. But there is no need for the psychiatric social worker to be circumscribed in his activities by this function. There are also residential settings in which the psychiatric social worker undertakes casework with individual child patients to good effect. In fact, even if we assume that working with the family is the principal role of the psychiatric social worker, we must also give full recognition to the fact that in order to do this work effectively, the psychiatric social worker must be thoroughly familiar with the problems of the individual child. Consequently, the two functions are clearly interrelated and interdependent. As there is a severe shortage of psychiatric social workers who are well trained for this work, the training of additional staff should have high priority in our institutions of higher learning.

The view was expressed by some physicians interviewed that doctors could play a more effective role in mental health if undergraduate training of physicians were reformed to provide more opportunities for specialized training. The curriculum of the new health science department at McMaster University has aroused considerable interest among physicians in this field. They view with approval the reform of the undergraduate curriculum to include general medicine and more psychiatry, rather than intensive knowledge in other areas of medicine. It was argued that there is no necessity for undergraduates in medicine to spend as many hours as they now do studying surgery, when only approximately 10 per cent of the graduating class will specialize in this field. In any case, in modern medicine only qualified surgeons are able to practise surgery. It was claimed that

an undergraduate curriculum which offers approximately two-thirds of the training in general medicine and one-third in psychiatry provides a much more useful background of knowledge for the family physician or general practitioner. A high level of importance was attached to family physicians with this kind of undergraduate training background by the professionals working in the area of child mental health.

Numerous psychiatrists interviewed were of the opinion that the most important role of the psychiatrist for the present is that of teacher. They considered that the most important contribution a psychiatrist can make in the field of mental health today is to impart to others the knowledge and expertise he has acquired and in this way multiply its benefits. The motive for this viewpoint is the severe shortage of personnel which is all too evident to the psychiatrist working in this field. It is with some reluctance that psychiatrists who are primarily motivated to do treatment take this view of their responsibilities. But many of them feel that unless more professional and subprofessional diagnosticians and therapists can be made available, there will be no improvement of the present situation in which they find themselves. At the present time, many professionals find that because of the way in which the demand for services and the need for services outstrips available resources, they are constrained to treat only severe and crisis problems, and find themselves frequently unable to inaugurate the kind of long-term treatment program which they deem to be in the best interest of the patient.

Although child care workers have to a great extent displaced nurses in the residential treatment centres for emotionally disturbed children, there is some argument that this profession could still be utilized for milieu therapy in these settings. One reason for supplanting nurses by child care workers has been the limited amount of psychiatric training received by nurses in the past. As an undergraduate, a nurse receives only three months of extensive psychiatric training. Also, in Ontario there are no graduate courses in psychiatry for nurses, such as the one offered in Quebec by McGill University. Given these facts, it may be more efficient to retain the nurse in her traditional role; for there is already an acute shortage of nursing personnel who are able to give general nursing care to patients. The addition of psychiatric training courses for nurses would not only deplete the existing body of nurses but would inefficiently employ personnel trained for another field.

Most experts in child psychiatry think that it would be preferable to train a new profession, such as the child care worker, to undertake milieu therapy with mentally ill patients. It is further reasoned that this concept is especially applicable to the field of child psychiatry where the area of expertise is highly specialized. Nevertheless, this argument does not negate the incorporation of more psychiatry into undergraduate nursing education, because the nurse can use psychiatric knowledge in her practice whatever her practice situation may be.

And nurses with a special interest in an aptitude for psychiatric nursing could provide valuable leadership for child care workers in residential treatment centres. Furthermore, the view was presented that the public health nurse with psychiatric training could play an important role in community mental health. Not only could she contribute to preventive psychiatry through her regular visits to families and individuals within the community, but she could also play a supportive role in relation to individuals in treatment. For example, the psychologist interviewed at East York-Leaside Mental Health Clinic reported a program in which he enlisted the support of public health nurses in the treatment of patients. This psychologist would treat a patient referred by the nurse only on the condition that she arrange to sit in on the treatment session. Eventually through this in-service training, the nurse learned how to treat her patients in their own homes during crisis periods.

Many residential treatment centres are in need of special school programs for children who are unable to attend a public school. There is a lack of teachers specially trained in this field. Most psychiatrists interviewed felt that the six-week diploma course offered by the Board of Education was inadequate, because it was purely academic and offered no adequate practical experience in the teaching of emotionally disturbed children. In this connection it may be noted that Boys Village is attempting to fill this gap, at least partially, through the operation of its day school for emotionally disturbed children. In this school, teachers who are in training at the Ontario College of Education in Toronto are able to gain practical experience. The notion that special education classes run by teachers with some psychiatric background can substitute in any way for treatment was rejected by child psychiatrists and other professionals interviewed.

Financing

In the past the hospital services for emotionally disturbed children have been financed in a variety of different ways according to the nature of the institution (general hospital, Ontario Hospital, residential treatment centre). It appears that under the legislation now under consideration in the Legislature, complete financing by the government under the Department of Health will be available for accredited residential treatment centres. The Act also empowers the Department of Health to establish more institutions of its own. It is to be hoped that the private sector will take the initiative and obviate any need for the government to create more mental institutions. An increase in government institutions would be a retrogressive step; it should be undertaken only if the private sector fails, and in such a way that the transition to community control can be easily effected.

Although Brown Camps Inc. has recently sold out to a non-profit corporation, it presents an interesting example of how the private sector can respond on either a profit or non-profit basis to adequate government incentives in the form of per diem allowances for children in treatment. The Children's Aid Societies

with which Brown Camps Inc. contracted for residential treatment of their wards paid to Brown Camps a per diem allowance of \$26.30 for each child so placed. This amount covered all costs incurred in the care and treatment of the child. A simple calculation provides a figure of approximately \$1,919,900 as the annual operating budget of Brown Camps Inc. during 1967, since they had 200 children in care. This figure increased substantially in 1968, as a result of both a further increase in the number of children in treatment and the increase in the per diem allowance from \$26.30 to \$29.60 on January 1, 1968. Out of this amount Brown Camps Inc. was able to finance a rather rapid and substantial capital development in the form of the acquisition of residential housing property in several locations. Once this initial capitalization process had been completed, Brown Camps would have been in a position to provide a much improved service on the basis of no increase in the revenues received. Thus from the financial point of view, Brown Camps Inc. is an interesting and instructive example of what can be achieved on a free enterprise basis through the establishment of residential treatment centres for emotionally disturbed children.

There was an irony involved in this development of Brown Camps; for it was financed essentially by the Department of Social and Family Services, certain senior officials of which were seeking the ruination of the former director of Warrendale. The inescapable predicament of these officials was that they had to support the Children's Aid Societies. The Societies, confronted with the problem of finding places for disturbed children in residential treatment centres, were satisfied to contract with Brown Camps for this service, since they found these centres to be at least as good as any others that were available. In any case, at that time no placements of any kind were available elsewhere.

Rather than have government-operated institutions it would be preferable for the government to provide per diem grants to institutions that met certain criteria: for example, 1) providing service to a manageable catchment area; 2) having a certain complement of professional staff in given categories; 3) carrying out a sound treatment program. These institutions should be organized and operated by groups of professionals or by communities along the lines of general hospitals. Essential to any system geared to quality of service is the reduction of bureaucracy, and control by qualified professionals and communities.

Research

Although the new Accreditation Board established by the Department of Health will provide for basic quality control, there remains a need for long-range studies of the efficacy of various types of treatment centres and treatment programs. At the present time, some research in this direction is being undertaken by Dr. Solursh at Toronto Western Hospital and by Boys Village.

There remains the need for a long-range independent study. At the present time, for example, there is widespread criticism of training, treatment methods

and procedures at Brown Camps. Retrogressive therapy is questioned by many psychiatrists, and even psychiatrists who do not disapprove of it as a treatment technique question the use of it by child care workers. It is in the interests of these mental health services to have controversies concerning training methods and treatment procedures removed as far as possible from the domain of inter-professional rivalry and politics, and placed in a context of scientific investigation. When this is done, controversy and experimentation become productive.

Location of Facilities

All professionals interviewed acknowledged the importance of instituting therapy or counselling programs for the families of emotionally disturbed children. Any hospitals of treatment centres with adequate professional resources have inaugurated such programs to the best of their ability as an essential part of the treatment of the child. Since these programs can be effectively carried out only if families live within manageable distances of the centre, these centres should serve limited catchment areas.

The second reason for this concept is the importance of close cooperation with other community agencies such as the schools, children's aid societies, juvenile court, community recreational centres, and so on. Residential treatment centres for emotionally disturbed children therefore should be part of a comprehensive community mental health centre, rooted in and linked to the community.

Instead of getting into the business of operating residential treatment centres itself, the government should be promoting and guiding a transitional phase of growth towards such community services.

Concluding Comment on Merit of Service

In conclusion, the most important single factor adversely influencing the quality of care and treatment for emotionally disturbed children in residential centres in the province is a lack of adequate numbers of professional and subprofessional personnel. This lack in combination with demand for service creates a tendency towards the dilution of service, because too little is being done for too many. A number of centres deliberately restrict the number of patients admitted so as to protect themselves against this threat to their own professional standards of service. Repeatedly in field interviews, the members of the mental health professions working in these settings emphasized the need for major improvements in prevention and treatment of emotional disorders in children and adolescents, supported by adequate follow-up programs which would insure the rehabilitation of the patient subsequent to hospitalization. The need for expanded outpatient services and for half-way homes for this purpose was strongly emphasized. It appears that the creation of a community mental health centre would be a major step in the direction of solving some of these problems.

Outpatient Facilities

There are four kinds of outpatient facilities: clinics, private practices, home and day centres, and special school facilities. At the present time clinics and physicians in private practice provide almost all the mental health outpatient services to disturbed children in the province. Clinics further subdivide into groups varying according to intensity of treatment.

These facilities also cover a wide spectrum in terms of the intensity, length and quality of treatment they can provide, ranging from private practitioners and highly developed clinics to the education-oriented services that treat emotional and relationship problems only tangentially, if at all.

Shortage of Facilities

Everywhere one finds serious shortages of facilities for the treatment of emotional disturbances in children on an outpatient basis. In London, for example, the only outpatient services are those at CPRI and the Mental Health Clinic at the Ontario Hospital; the Child Guidance Clinic at Victoria Hospital has discontinued its therapeutic program. CPRI treats mainly retarded children. The Ontario Hospital Clinic has long waiting lists and a high percentage of broken appointments, because of the large area it serves and the long distances some families have to travel to reach it. Fortunately, London relative to other cities has many psychiatrists in private practice.

Some data for major clinics in Toronto and Kingston provide a representative impression of the scope of the problem. Demand for services at the Sick Children's Hospital Clinic has forced the psychiatric clinic to restrict its service to approximately 1,450 appointments per year. Rather than diagnose a large number of patients of whom they can treat only a small percentage, the staff at the outpatient service have decided to give quality service to a smaller number of patients. Consequently, they must turn away many children who need treatment. There are thirty to forty children in treatment at any given time.

TABLE 13.4

Number of Applicants as Compared with Those Taken into Treatment at the Sick Children's Hospital Clinic, Toronto, 1966

Patients	Applied for treatment	Treated
Children under 5	66	43
Children 5-11	249	224
Children 12-21	132	120
Total	447	387

SOURCE: C. Hanly and P. Centner, *Mental Health Survey, Outpatient Facilities for Children* (Study 8), 1967. Based on a questionnaire returned by the Sick Children's Hospital.

Table 13.4 provides some measure of the problem, although it is no doubt a conservative one since physicians referring to the hospital's service will be familiar with its policy and may well refrain from referring all the patients they would like to.

The reason for the restriction of service is obvious from Table 13.5. It is wasteful to provide anything less than the most effective treatment possible, because otherwise the problems will only recur. All of the best clinics have restrictions in order to reduce the numbers of patients going from clinic to clinic or returning to the same clinic without real remedy.

TABLE 13.5

Number of Patients Treated for the First Time as Compared with Those Treated Previously (Sick Children's Hospital Clinic)

Patients	Treated for the first time	Treated in a previous year at this clinic or elsewhere
Children under 5	41	2
Children 5-11	195	29
Children 12-21	103	17
Total	339	48

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatients Facilities for Children* (Study 8), 1967.

A similar situation was found in the clinic operated by the Kingston General Hospital. These clinics were selected for presentation here because they were representative of clinics that had specialized outpatient services for children.

TABLE 13.6

Number of Applicants as Compared with Those Taken into Treatment at the Kingston General Hospital Clinic, 1966

Patients	Applied for treatment	Treated
Children under 5	23	18
Children 5-11	132	105
Children 12-21	186	149
Total	341	272

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatient Facilities for Children* (Study 8), 1967.

The same situation exists in community clinics. For example, the Hamilton Mental Health Clinic had a waiting list of 250. Immediate attention is given only to the critical cases; less severe cases must wait up to one year.

TABLE 13.7

Number of Patients Treated for the First Time as Compared with Those Treated Previously (Kingston General Hospital Clinic)

Patients	Treated for the first time	Treated in a previous year at the clinic or elsewhere
Children under 5	17	1
Children 5-9	96	9
Children 10-16	136	13
Total	249	23

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatient Facilities for Children* (Study 8), 1967.

The situation at the Borough of York Child and Family Psychiatric Clinic is representative.

TABLE 13.8

Number of Applicants as Compared with Those Taken into Treatment at the Borough of York Child and Family Psychiatric Clinic, 1966

Patients	Applied for treatment	Treated
Children under 5	4	4
Children 5-11	71	52
Children 12-21	57	47
Total	132	103

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatient Facilities for Children* (Study 8), 1967.

The clinic treats only fifty patients a year — a meagre number, considering the size of the catchment area it serves. However, as pointed out above, this quality treatment is more worthwhile in the long run than superficial treatment given to a large number of patients.

Clinics are not the only facilities offering intensive outpatient care to emotionally disturbed children. Private psychiatrists probably provide some of the best treatment. However, the number of their clients is limited by time, cost and social factors. Dr. Paul Steinhauer, the only private child psychiatrist interviewed, had given up almost all his community work in order to devote his time to private cases. He still considers teaching essential and devotes several hours a week to the Provincial Institute of Trade's Child Care Worker Programme. Dr. Steinhauer insists on collaboration with the entire family, giving therapy to the family and the individual on a ratio of two interviews to one. He finds that often problem children are the result of a disturbed family that cannot exist as a unit unless one member is sick. The task of the psychiatrist is to help the members of the family understand and correct this basic flaw in their living. Dr. Steinhauer gives full

treatment to any patient applying for therapy, regardless of prognosis. He reported some success with supposedly untreatable schizophrenic children. Once the family and child have decided to receive psychotherapy from him, Dr. Steinhauer makes certain they get complete treatment. He sees no point in giving superficial or incomplete treatment.

It is not possible to determine how many more child and juvenile psychiatrists in private practice are needed. All that is certain is that there is no danger of ever having too many of them at current rates of increase. It has been estimated that at least 10 per cent and perhaps 15 per cent of all school children need specialized mental health services.

Legislation and Accrediting Procedures

There are no accrediting procedures for outpatient clinics per se or for those specializing in children's services. The standards of clinics are maintained through the standards of the professionals who work in them. Certain American states have legislation for accrediting mental hygiene clinics which require, for example, a certain complement of professional staff — psychiatrists being mandatory. Such legislation might be considered in Ontario, although no special need for it was uncovered by the research for this report.

Professional and Subprofessional Requirements and Treatment Policies

What has already been said concerning professional requirements in connection with residential centres applies here, except that child care workers have no role in outpatient services.

A questionnaire survey of outpatient services for children was made of forty-two outpatient services in the province. Twenty-eight, or 66 per cent, were returned of which twenty-three are included in the data summarized in Table 13.9. North Bay and Owen Sound reported that their outpatient services had been closed through lack of staff. Northwestern General has no outpatient service, although one is listed in provincial lists. The Oshawa Mental Health Clinic was opened in 1967, and the Ottawa Civic's outpatient department is for adults only. Those reporting and included are Ontario Hospitals: Goderich, New Toronto, Port Arthur, St. Thomas, Toronto, Whitby, Woodstock; and Community Hospitals: Cornwall General, Hamilton General, Hospital for Sick Children, Western-Humber Memorial, Kingston General, Kitchener-Waterloo General, North York, Ottawa General, Ottawa Royal Sanatorium, Queensway General, St. Catharine's General, Toronto General, London Victoria, Windsor Community, Newmarket-York County, Borough of York Mental Health Clinic.

The totals in the first column are not compatible with the totals in the last column, because some patients' totals were given which were not then further subdivided into the categories in the questionnaire (columns 2, 3, 4, 6). However,

TABLE 13.9
Diagnostic and Treatment Patterns in Outpatient Services in Ontario According to Age Categories
 (Total all professionals: 209)

Service received	Reported total	Age category						Total children of total	Per-centage of total	Total categorized
		-5	Per-centage of total	5-11	Per-centage of total	12-21	Per-centage of total			
Total applications	8,878	357	5	1,830	29	1,204	19	3,391	53	6,366
Total treatments	8,159	228	4	1,330	23	1,041	18	2,599	45	5,829
Total treatments (1st time)	5,933	168	4	1,030	28	815	22	2,013	54	3,753
Diagnosis: Psychosis	1,020	19	3	38	6	118	19	175	28	621
Psychoneurosis	2,036	18	1	81	7	208	17	307	25	1,206
C & B disorders	2,849	92	6	603	40	341	22	1,036	68	1,514
Other	894	28	5	146	29	107	21	281	55	511
Treatment:										
Psychotherapy a) Individual	8,523	10	1	362	47	393	52	765	100	765
b) Group	696	0	0	95	49	98	51	193	100	193
Hours:										
Psychotherapy a) Individual	24,684	22	.3	4,064	56.7	3,076	43	7,162	100	7,162
b) Group	1,609	61	6	836	75	212	19	1,109	100	1,109
Psychoanalysis	—	—	—	—	—	—	—	—	—	—
Hours:										
Psychoanalysis	—	—	—	—	—	—	—	—	—	—
Counselling a) Individual	2,692	43	12	177	49	142	39	362	100	362
b) Group	219	39	18	111	53	62	29	212	100	212
Hours:										
Counselling a) Individual	9,584	109	2	2,848	62	1,643	36	4,600	100	4,600
b) Group	723	77	17	166	37	211	46	454	100	454
Other	4,417	—	—	—	—	—	—	602	100	602
Hours: Other	1,740	—	—	—	—	—	—	—	—	—

SOURCE: C. Hanly and P. Centner, Mental Health Survey: Outpatient Facilities for Children (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

columns 2, 3, 4, 5 (the sum of 2, 3, and 4) and 6 are consistent with the last column, which presents categorized totals. The table shows a rather surprisingly high level of applications on behalf of children (anyone under twenty-one years) as compared with adults. This is because the data are biased towards services that specialize in the treatment of children, although it is possible that even when this bias is discounted an increase in the relative demand for child, as compared with adult, psychiatry is indicated.

The table shows, as one would expect, that neurosis is a relatively infrequent diagnosis for the age group under twenty-one years as compared with adults, and the reverse applies to the diagnosis of character and behaviour disorder. The table also confirms the finding that individual psychotherapy is by far the most common form of treatment. If one takes individual psychotherapy separately and compares it with other non-psychodynamic therapies, one finds that almost twice as many patients were treated by psychotherapy. If one compares the psychodynamic therapies with the non-psychodynamic, one finds that almost three times as many patients were treated by the former method. When considered from the point of view of the quantity of professional resources in man-hours that is devoted to psychotherapy and counselling as compared to other treatment methods, the difference is magnified many times: twenty-one times as many hours went into treating patients by means of psychotherapy and counselling as went into other

TABLE 13.10

Number of Professionals in Twenty-three Outpatient Services in Ontario

Ratio: Professionals/100 applicants	2:2
Ratio: Professionals/100 child applicants	5:1
Physicians a) Psychiatrists	73
b) G.P.'s	16
Psychologists a) Ph.D.	14
b) M.A.	26
c) B.A.	9
Social workers a) M.S.W.	27
b) B.S.W.	12
c) Other	16
Psychiatric nurses	7
Child care workers	4
Special teachers	3
Psychoanalysts	—
Other (speech therapists)	2
Total	209

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatient Facilities for Children* (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

methods of treatment. Thus psychotherapy is unquestionably the single most important form of treatment. It is all the more important for these reasons to consider ways of increasing the number of psychotherapists by increasing the number of non-medical psychotherapists.

The breakdown of staff in the twenty-three clinics included in the summary is reported in Table 13.10. The table shows the preponderance of medical personnel in these services. There are almost twice as many physicians as psychologists or social workers. The comparison of ratios of professionals to patients was made by subtracting the three clinics that specialized in treatment of children and calculating their aggregated staff:patient ratios separately. The ratios for children in these three clinics are strikingly better than the average ratios for adult services. Part of the explanation is that the mass-produced treatments such as drugs or electroconvulsive therapy that are used with some adults are not used with children, and the more time-consuming psychological therapies must be used.

Table 13.11 shows the distribution of functions among the different professionals. The most interesting feature of the data is the relatively uniform distribution of the five major functions enumerated among the professions.

Table 13.12 summarizes the extent and nature of training programs in the clinics. The data suggest that the current training programs will perpetrate the existing proportions among the three major mental health professions. What is striking is the number of psychiatric nurses and child care workers being trained.

Table 13.13 summarizes data concerning the clinic's priorities for additional staff. Its most striking feature is the high rating given to psychoanalysis, which greatly exceeds the rating given by psychiatrists generally.

The clinic also rated their priorities for additional facilities (Table 13.14). The preponderant need is for more clinics in which children can be treated on an outpatient basis.

TABLE 13.11
Duties Performed by Different Professionals in Twenty-three Outpatient Services in Ontario

Personnel	Primary diagnosis	Secondary diagnosis	Therapist	General care	Education
Psychiatrist	54	7	66	25	50
G.P.	9	5	10	4	2
Psychologist	19	27	40	7	15
Social worker	13	21	31	36	14
Psychiatric nurse	3	1	6	6	3
Child care worker	—	3	3	3	—

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: Outpatient Facilities for Children* (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

TABLE 13.12
**Number of Units Providing Training, Students in Training,
and Total Teachers Available**

Training provided for	No. of units	No. of students	
Psychiatrists	8	44	
Psychologists	12	32	
Social workers	6	17	
Psychiatric nurses	4	108	
Child care workers	4	140	
No training provided	7		
	<u>Full time</u>	<u>Part time</u>	<u>Total</u>
Staff (teaching)	44	64	108

SOURCE: C. Hanly and P. Centner, Mental Health Survey: Outpatient Facilities for Children (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

TABLE 13.13
Rating of Various Professional Needs by Twenty-three Outpatient Services

Requirements	Rating 1	Rating 2	Rating 3	No rating
Psychiatrists	11	2	2	9
Psychoanalysts	5	6	3	7
Psychologists	2	4	4	12
Psychiatric nurses	2	8	3	6
Social workers	4	—	2	12
Child care workers	4	4	4	11
Teachers	—	—	1	17

SOURCE: C. Hanly and P. Centner, Mental Health Survey: Outpatient Facilities for Children (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

TABLE 13.14
**Rating of Various Facilities According to Need
by Twenty-three Outpatient Services**

Requirements	Rating 1	Rating 2	Rating 3	No rating
Clinics	13	6	2	4
Units in general hospitals	8	5	2	8
Private hospitals	2	2	3	11
Others	2	2	3	15
Ontario Hospitals	1	3	2	12

SOURCE: C. Hanly and P. Centner, Mental Health Survey: Outpatient Facilities for Children (Study 8), 1967. Based on a questionnaire survey of Ontario outpatient services.

Field work on the outpatient services for emotionally disturbed children has made it apparent that professional cooperation and equal sharing of responsibility is the rule rather than the exception. The two factors that seem to act as limits are the training of the psychologist, which often falls short of what is needed for high quality psychodiagnosis and psychotherapy, and the tradition of medical authority, which is reinforced legally, economically and socially. However, in numerous clinics where the first factor is not present, full professional parity is a practical fact. Even so, it is likely that for the most part and for the foreseeable future either clinical directors will have to be psychiatrists, or the clinics will have additional difficulties in securing the services of psychiatrists on a full-time basis. In general, those services that are supervised by psychologists tend to be services in which psychiatrists are not much interested, such as reform institutions and schools.

The best way to correct this situation is to train more highly skilled non-medical psychodiagnosticians and psychotherapists in the form of non-medical psychotherapists in a program that will have the confidence of medicine — that is, one along the lines suggested by Kubie.

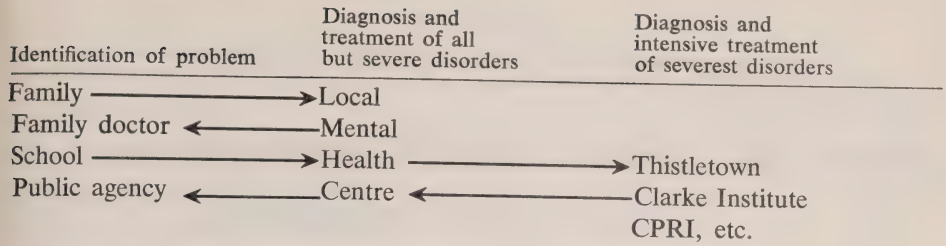
The outpatient and inpatient services that premise their work on the family treatment principle both provide a precise definition of the major role of the psychiatric social worker and appear to make the most effective use of his professional resources. Because he is trained to do casework with families and to observe economic, social and psychological determinants of family problems, the psychiatric social worker appears to be ideally suited to undertake psycho-social therapy with the families of children who are receiving intensive individual treatment.

There is, of course, a serious shortage of psychiatric social workers, as there is of all the professional and subprofessional personnel in this area. To their number may now be added special teachers. Unless this problem is solved, the problem to be discussed next also will remain insoluble.

Location and Nature of Facilities

Field interviews revealed almost universal agreement among psychiatrists, psychologists and social workers who are now operating the province's inpatient and outpatient services for emotionally disturbed children concerning the need for many more well-staffed *local* mental health centres. Mental health personnel, in both public and private hospitals, as well as those working in community clinics, were practically unanimous that the lack of these facilities is a major gap in the province's mental health services. This gap seriously disrupts the natural, most effective, and most economic pattern of utilization of available resources. The following flow chart represents what would be considered a desirable system.

As the chart indicates, the local mental health centre occupies a crucial position in the identification-diagnosis-treatment-rehabilitation process in two respects: 1) it makes possible the diagnosis and treatment of many patients on an outpatient



basis, thus avoiding the necessity of their even having to be referred to an intensive treatment unit for hospitalization; 2) it makes post-hospitalization treatment and rehabilitation practical and more effective for patients who need hospitalization. What is *most* needed, therefore, is not more and more centres specializing in the intensive residential treatment of emotionally disturbed children, but many more well-staffed community mental health centres which will make possible the effective utilization of the existing hospital and residential resources.

These centres would also go some way towards solving the problems presented by the child whose personality growth problems are associated with the permanent breakdown of the family of which he is a member, and who must be taken into care either in a foster home or in a residential centre. Small residential centres in which basic care is provided by child care workers under the supervision of, and in cooperation with, professionals at local mental health centres would be feasible. More specific intensive treatment also could be given when needed.

It should be obvious, however, that nothing can be done to improve facilities until the basic problem is solved: the training of sufficient numbers of professionals and subprofessionals. This shortage in both staff and facilities generates a dilemma that was clearly articulated by almost all professionals interviewed in almost all clinics visited: *should all demands for service be met, however inadequately, or should treatment be given on a selective basis governed by the capacity of the clinic to give quality treatment.* There is some pressure to see as many patients as possible, but most professionals resist it because it results in a rapidly diminishing return on diagnostic and therapeutic investment. Some small clinics could devote most of their time to diagnosis and assessment, but the futility of knowing what the problems are without being able to do anything about them is recognized by everyone. Furthermore, an inadequate treatment program is no better than none at all, since progress will only be temporary and will be quickly erased when the influence of the therapist is removed. Faced with this dilemma most of the clinics visited, and all of the best organized, best staffed clinics visited, adopt a policy of restricting services in the interest of preserving quality. In a just society which is also an affluent society, this method of protecting quality of professional service should not be necessary.

Chapter 14 Mental Health Services in the Schools and Universities

It is generally acknowledged by professionals in the field that the schools provide a natural and effective place for the early identification of mental health problems. There are two operative factors. First, the school is, for most children, the most important social institution outside their family. Their ability to adapt successfully to its demands and fully utilize its resources is a major indicator of the quality of their family experience and of their long-term personality development. Thus, quite apart from its intrinsic educational role which requires it to be able to deal with physical handicaps which cause learning problems, the school could function as an early warning system for emotional disorders. Second, it is thought by some mental health professionals that the school system should include both diagnostic and treatment services for children with emotional, developmental and behaviour problems. The Hall-Dennis report on public school education in Ontario also advocates the creation of school mental health clinics.¹

A major barrier to achieving this objective is the unavailability of the necessary professional staff. It is not at all clear when, if ever, there will be professional staff available for this purpose. The results of even a rather inadequate questionnaire survey indicate the magnitude of the problem.

Professional Resources in the School System

Questionnaires concerning mental health services in the schools were distributed to school boards (see Table 14.1). Not all inspectorates in each area received questionnaires. Experience indicated that rural inspectorates could not be expected to have any of the services the questionnaire was investigating; therefore they were sent only to municipal inspectorates in each of the ten areas. The figures showing actual numbers of professionals do not represent a census except for the areas in which every municipal inspectorate returned the questionnaire, and when the assumption that rural inspectorates do not have mental health services is corrected.

The areas to which questionnaires were sent and returned are listed in the

¹*Living and Learning*, Provincial Committee on Aims and Objectives of Education in the Schools of Ontario, 1968. See especially the chapter entitled "Special Learning Situations".

TABLE 14.1
Questionnaire Distribution and Response

Area #	Description	No. of Questionnaires Sent	Returned	Percentage of Total
1	Northwestern Ontario	2	1	50
2	Midnorthern Ontario	2	2	100
3	Northeastern Ontario	1	1	100
4	Western Ontario (London)	5	4	80
5	Midwestern Ontario	8	5	63
6	Niagara (Hamilton)	9	8	89
7	West central Ontario (Toronto)	10	7	70
8	East central Ontario (North York)	9	6	67
9	Eastern Ontario (Peterborough)	5	5	100
10	Ottawa Valley	5	5	100
Total	Whole province	56	44	79

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: School Boards (Study 5)*, 1967. Based on a questionnaire survey of inspectorates in ten regions of Ontario.

table. (The inspectorates to which they were sent in each area and those that returned them are listed along with a copy of the questionnaire in the appendix to this study.)

For the purpose of this discussion the most important data on the questionnaires were the number and type of professional personnel serving the mental health needs of children in the schools in these different areas. Included in the categories of professional personnel were physicians (psychiatrists and non-psychiatrists), psychologists (Ph.D., M.D. and B.A.), social workers (M.S.W., B.S.W. and other), special teachers, and others. There are inescapable ambiguities concerning each of these professional categories. A psychiatrist is clearly a mental health professional; another physician is unlikely to be, although he may be. A psychologist with a Ph.D. may or may not have been trained in psychodiagnosis and psychotherapy. For example, an educational psychologist will not usually be trained in mental health. The same applies to social workers. Psychiatrists interviewed were skeptical about the capacity of special teachers to do anything more than teach academic subjects to emotionally disturbed children. This is an important and necessary improvement, but is not in itself an adequate substitute for treatment based on psychodiagnosis. In the category of "other" were included home instruction teachers, special education consultants, guidance supervisors and counsellors, speech therapists, social adjustment counsellors, and academic adjustment counsellors. Furthermore, in some cases the professionals were giving only part-time services. These ambiguities and their effect on the data cannot be quantified and subtracted. However, their net effect will be to make the services

TABLE 14.2
Professional Services in Ontario Schools, by Region

Profession	AREA: Actual Number of Each Profession Reported The Ratio per 10,000 School Children And the % of the Average Ratio for the Province										Col. 1	Col. 2	Col. 3
	1			2			3			4			5
Psychiatrists	—	—	—	—	—	—	—	—	—	—	—	—	—
Other physicians	—	—	—	1	.5	(835)	—	—	—	1	.1	(167)	—
Psychologists													
Ph.D.	—	—	—	—	—	—	—	—	—	10	1.	(333)	1 .2
M.A.	—	—	—	1	.5	(50)	—	—	—	4	.4	(40)	4 1.
B.A.	—	—	—	—	—	—	—	—	—	—	—	—	1 .2
Total psychologists	—	—	—	1	.5	(27)	—	—	—	14	1.	(78)	6 1.5
Social workers													
M.S.W.	—	—	—	—	—	—	—	—	—	—	—	—	—
B.S.W.	—	—	—	1	.4	(920)	—	—	—	—	—	—	1 .2
Other	—	—	—	—	—	—	—	—	—	—	—	—	—
Total social workers	—	—	—	1	.5	(131)	—	—	—	—	—	—	1 .2
Special teachers	1	.9	(15)	17	8.	(102)	—	—	—	109	11.	(183)	9 2.
Others	—	—	—	1	.5	(667)	—	—	—	34	3.5	(507)	—

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: School Boards (Study 5)*, 1968.
 Based on a questionnaire survey of inspectorates in ten regions of Ontario.

appear to be better than they really are, and they do not appear to be very good even so. Table 14.2 presents the most general picture of the availability of professional mental health resources in the school areas studied.

Table 14.2 delineates the availability of various mental health professionals in the ten regions studied. For each type of professional in each area, three figures are shown of which the first represents the number of professionals of the given type serving children in the area's schools; the second represents the ratio of these professionals to the school population in the area; and the third represents the number of these professionals as a percentage of the average number for all areas. This last figure provides a basis for comparing each area against the norm for the province as defined by the average.

There are only ten psychiatrists serving forty-four of fifty-six school boards in the province. All are located in Metro Toronto. Area 7 (Toronto) also has the largest number of psychologists and social workers, followed by Area 10 (Ottawa Valley). The Ottawa Valley has a psychologist:student ratio that is one and one-half times better than the provincial average, while Toronto's is only one and one-third times better than the provincial average. Midwestern Ontario is precisely average in its psychologist:student ratio. Two areas have no psychologists at all. These are Northwestern Ontario and Northeastern Ontario. Toronto greatly exceeds every other area in the number of social workers by all three criteria. It has a greater absolute number; it has the best social worker:student ratio; it is a little more than twice as good as the provincial norm. Toronto also

6			7			8			9			10			Total		
—	—	—	8	.3	(272)	1	.05	(45)	1	—	—	—	—	—	10	.1	(100)
—	—	—	2	.1	(167)	—	—	—	—	—	—	1	.2	(334)	5	.06	(100)
1	.1	(33)	4	.2	(66)	5	.2	(66)	1	.3	(100)	5	.8	(266)	27	.8	(100)
4	.5	(50)	28	1.	(200)	25	1.	(120)	5	.3	(30)	11	2.	(170)	78	1.	(100)
1	.1	(16)	28	1.	(200)	13	.8	(100)	—	—	—	1	.2	(33)	44	.6	(100)
6	.8	(44)	60	2.5	(138)	43	2.	(100)	2	.5	(27)	17	3.	(150)	149	2.	(100)
1	.1	(53)	18	.7	(208)	4	.2	(77)	—	—	—	1	.1	(578)	24	.2	(100)
—	—	—	1	.05	(100)	—	—	—	—	—	—	1	.1	(300)	4	.05	(100)
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	(100)
1	.1	(40)	19	.8	(202)	4	.2	(57)	—	—	—	2	.3	(88)	28	.35	(100)
52	7.	(109)	75	3.	(52)	56	4.	(70)	24	.6	(102)	139	21.	(359)	482	6.	(100)
8	1.	(145)	9	.4	(58)	3	.1	(22)	—	—	—	—	—	—	55	.7	(100)

relies less on special teachers, whereas Area 4 relies very heavily on them. Area 4 makes by far the greatest use of special teachers of any school region. Area 4 has two and one-half times the special teacher:student ratio that is the norm for the province.

In general, when the distribution of mental health professionals within the school regions of the province is analyzed more closely one finds that 1) scarcely any substantial progress has been made in introducing effective mental health services into the school system; 2) there are not enough professionals to establish workable professional:student ratios; and 3) there are gross regional inequalities.

The relative weighting of each type of professional within each area is exhibited in Table 14.3. The numerical value represents the percentage of each profession within each area.

Table 14.3 reinforces the three general conclusions already established on the basis of Table 14.2. It also makes very clear that in terms of current training practices and professional standards, there is practically *no* professional base in the school system on which to build the services envisaged in the Hall-Dennis Report on education. Psychiatrists, for example, represent only 1.2 per cent of current professional resources. Ph.D. psychologists, of whom probably most are equipped at best to do only testing and assessment but not therapy, number only 3.7 per cent. M.S.W. social workers, who also are not trained in therapy, comprise only 3.8 per cent of current professional resources. In other words,

TABLE 14.3
Relative Weighting of Different Professions in Mental Health
Services in the Schools of the Province, by Region

Profession	School area									Province	
	1	2	3	4	5	6	7	8	9	10	Total
Psychiatrists	—	—	—	—	—	—	4.6	.9	—	—	1.2
Non-psychiatrists	—	4.8	—	.6	—	—	1.2	—	—	.6	.7
Psychologists:											
Ph.D.	—	—	—	6.3	6.3	1.5	2.3	4.7	3.8	8.1	3.7
M.A.	—	4.8	—	2.5	25.0	6.0	16.2	23.4	3.8	6.9	10.1
B.A.	—	—	—	—	6.3	1.5	16.2	12.2	—	.6	6.0
Total	—	4.8	—	8.9	37.5	9.0	34.7	40.2	7.7	10.7	19.8
Social workers:	—	—	—	—	—	1.5	10.4	3.7	—	.6	3.3
M.S.W.	—	—	—	—	—	—	—	—	—	—	—
B.S.W.	—	4.8	—	—	6.3	—	.6	—	—	.6	.5
Other	—	—	—	—	—	—	—	—	—	—	—
Total	—	4.8	—	—	6.3	1.5	11.	3.7	—	1.3	3.8
Special teachers	100	81.	—	69.	56.2	79.0	43.3	56.0	92.3	87.4	66.3
Others	—	4.8	—	14.	—	11.9	5.2	2.4	—	—	7.6

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: School Boards (Study 5)*, 1967.
 Based on a questionnaire survey of inspectorates in ten regions of Ontario.

the existing resources, quantitatively inadequate as they are, are also functionally inadequate for the purposes of a mental health service, since they are limited almost entirely to diagnosis, testing, assessment and special education. The missing element is *therapy*.

Table 14.4 shows the number of professional personnel working for the school system in each of the ten school regions deemed by the school board to be competent to perform one of five major functions: primary diagnosis, ancillary diagnosis, treatment, general care, education. (Ancillary diagnosis is a supporting diagnosis — such as an I.Q. test or personality assessment — used in, but not in itself sufficient for, making a complete final diagnosis; by “education” in this context “special education” is always understood.) The other two numbers in each subdivision of the table represent the professional:student ratio with respect to the function and the percentage represented by this ratio of the average ratio for the province, in that order.

Table 14.4 sets out the percentage of the professionals in each area who are competent to perform the five functions enumerated. It will be noticed that the total of these percentages is greater than 100 per cent. This results from the fact that a single professional may perform a number of different functions.

Table 14.4 shows three areas (Areas 1, 2 and 3) as having no diagnostic or treatment services in the school system. Area 9 has one diagnostician for every 20,000 students; Area 8 has one; Area 5 has two; Areas 4 and 7 have three;

TABLE 14.4
Distribution of Professionals According to Service Capabilities in Ten Ontario Regions

Function	School Area: The Number of Reported Professionals Performing Any Function Their Ratio Per 10,000 School Children And the % of the Average Ratio for the Province									
	1	2	3	4	5	6				
	—	—	—	—	—	—	—	—	—	—
Primary diagnosis	—	(—)	—	10 1.0 (85)	4 1.0 (81)	7 1.0 (75)				
Ancillary diagnosis	—	(—)	—	15 1.0 (102)	5 1.0 (94)	41 5.0 (402)				
Total	—	(—)	—	25 3.0 (103)	9 2.0 (88)	48 6.0 (245)				
Therapy	—	(—)	—	9 1.0 (168)	3 1.0 (158)	4 0.5 (102)				
General care	—	(—)	—	8 1.0 (64)	2 0.5 (38)	9 1.0 (88)				
Education	1 0.1 (126)	—	—	129 13.0 (176)	14 3.0 (45)	69 9.0 (116)				

Function	7	8	9	10	Total
	45 2.0 (157)	10 0.5 (41)	1 0.3 (22)	18 3.0 (227)	95 1.0 (100)
	25 1.0 (81)	8 0.3 (30)	1 0.3 (20)	10 1.5 (121)	105 1.0 (100)
Ancillary diagnosis	70 3.0 (118)	18 1.0 (35)	2 0.5 (20)	28 4.5 (176)	200 2.5 (100)
Total	—	(—)	1 0.3 (64)	9 1.5 (296)	133 0.5 (100)
Therapy	66 3.0 (201)	2 0.1 (8)	—	19 3.0 (203)	106 1.0 (100)
General care	147 6.0 (81)	69 3.0 (45)	25 6.0 (88)	155 2.5 (32)	609 7.5 (100)
Education					

SOURCE: C. Hanly and P. Centner, Mental Health Survey: School Boards (Study 5), 1967. Based on a questionnaire survey of inspectors in ten regions of Ontario

Area 10 has 4.5; and Area 6 has six per 10,000 students. The best ratio is inadequate, and we have already seen that the diagnostic service itself cannot be of the best standard because of the gross shortage of highly trained personnel.

As far as treatment is concerned, the situation clearly is much worse. Ratios nowhere exceed one therapist for every 10,000 students, while the provincial average is one therapist for every 100,000 students.

It is only with respect to special education that anything remotely approaching adequate ratios is achieved, with the highest ratio being thirteen special educators for every 10,000 students. The provincial average is 7.5. However, one must also note two regions, Areas 2 and 3, with no special educators and another, Area 1, which has a total professional complement of one special teacher.

If one reflects for a moment on what a special educator can accomplish in terms of numbers of students, one can appreciate to what extent the province is deficient even in this area. If the children have real learning handicaps, they will need individual attention, and a class of twenty would seem to be large. Thirteen such teachers could teach only 260 children for one year in classes of twenty. Hence only 260 children out of every 10,000 in the school area with the best special teacher student:ratio could be accommodated in any year. Some, at least, of this number would require more than one year of special classes in order to consolidate and maximize benefits. Consequently, fewer than 260 new children out of every 10,000 could be accommodated in any year. At a conservative estimate, 2 per cent of any school population will suffer from a severe mental handicap, such as brain damage, retardation or psychosis. Thus approximately 200 of 10,000 children will have an urgent need for special education of this type. Children who are emotionally disturbed and children with organic sensory problems are *not* included in this estimate. Therefore, the best region in the province is not even adequate in the area of special education for dealing with the most severe cases.

TABLE 14.5
Percentages of Professions Providing Diverse Mental Health Services
to Ontario School Children, by Region

Function	School Area										Prov. Total
	1	2	3	4	5	6	7	8	9	10	
Primary diagnosis	—	—	—	6.3	25.0	3.9	25.7	9.3	3.8	11.3	12.3
Ancillary diagnosis	—	—	—	8.3	31.2	22.8	14.5	7.5	3.8	6.3	12.4
Total	—	—	—	13.8	57.8	26.7	40.4	16.9	7.7	17.6	23.8
Therapy	—	—	—	5.0	18.8	2.2	—	11.2	3.8	5.6	4.5
General care	—	—	—	4.4	12.5	5.0	38.0	1.8	—	13.8	12.6
Education	100	—	—	71.6	87.8	38.3	84.9	4.7	96.2	97.8	72.1

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: School Boards (Study 5)*, 1967. Based on a questionnaire survey of inspectorates in ten regions of Ontario.

As far as treatment is concerned, the ratio of therapist:student in the school system for the province is 1:100,000 according to Table 14.4. Table 14.5 confirms both the particular (area by area) and the general shortage of therapists in the school system. Of the professionals giving mental health services through the school system 23.8 per cent are competent to diagnose, or test and assess; only 12.3 per cent are competent to undertake a primary psychological diagnosis; and 72.1 per cent are equipped as special teachers. Only 4.5 per cent are therapists.

The Major Barrier to Improved Services

Treatment is the major bottleneck. Identification of a problem child usually occurs in the school system; rudimentary diagnostic services are available in some areas; and in most areas some special classes also are available. For children who need treatment as well as special education, there are practically no services.

One can analyze the process whereby assistance is brought to emotionally disturbed children (as indeed, to any other individual with mental health problems) according to three stages: problem identification, diagnosis, and treatment. There are two major effects of the manpower situation documented above. In the worst regions there is a bottleneck at the point where problem identification should lead to diagnosis. In the best regions the major bottleneck is moved one stage along and is located at the point where diagnosis should lead to treatment. It is worth documenting these effects a little more precisely by considering two specific local regions which illustrate each rather well.

Impact of the Lack of Professional Resources in Two Areas

Huron County was selected as a fairly typical rural area. It is composed of farms and small towns. Its largest town is Goderich, which has a population of less than 10,000. It is not entirely devoid of psychological and psychiatric services, because there is an Ontario Hospital located near Goderich. Efforts are being made to provide psychological services for children and adolescents in the area outside the school system through the outpatient service of the Ontario Hospital, Goderich. But although Huron County is in an area which is relatively well supplied with special psychological and social services for school children, the professionals in these services are located in London and are not available to the schools of Huron County. Consequently, its school population of 14,116 students (elementary and high school combined) has available to it no mental health diagnostic, treatment or special education services within the schools themselves. Neither are resources available outside the school system. As reported elsewhere, the Ontario Hospital at Goderich has established an outpatient department which in 1966 gave treatment to two children aged five to eleven, and to twenty-five aged twelve to twenty-one. The Hospital has plans for expanding the outpatient services for children but continues to experience great difficulty in securing the necessary staff. The County Health Officer has not been successful in his efforts to establish a

county mental health clinic, in part because of resistance from local politicians, in part because there are no professionals to hire even if funds should become available. The Children's Aid Society, which is related only tangentially to the needs of a small segment of the school children of the area, is visited once a month by a psychologist for consultation purposes. In essence, no services are available. Early detection and prevention of mental illness in the schools are empty words as far as Huron County is concerned.

What is the magnitude of the need? Experts state that 10 per cent of school children will be in need of and would benefit from mental health services sometime during their school careers (during the period of growth between five and sixteen years of age). This estimate appears conservative in the light of the studies cited in Part One of this report. This means that over any eleven-year period approximately 1,400 children in the county will need and would benefit from mental health services. But they will never receive them. Even if one adopts the premise of this report and takes one-half of these estimates as the basis of a realistic immediate goal, one is still confronted with the problem of supplying services for 700 children. To treat this number of students, assuming a relatively uniform distribution of problem children over time and assuming that intensive treatment including special classes would be needed for only one year on the average, a team of three psychologists or psychiatrists trained in psychodiagnosis and psychotherapy, three psychiatric social workers, and six special teachers might prove adequate to the demands of the tasks involved. The fact is that at the rate at which current training programs are producing professional mental health personnel, there is no prospect of the province reaching this kind of goal in the foreseeable future.

Some impression of the nature of the obstacles in the way of utilizing the school system as an early warning system for prevention may be formed by realizing that Huron County is only one of many similarly backward rural jurisdictions. Society and its official representative, government, may be saved from embarrassment by the relative ignorance of the citizens of rural communities concerning mental health needs and their treatment. But, unfortunately, that defence is only a barrier in the way of progress towards a more healthy, productive society.

For the sake of comparison, an urban area which has relatively well developed psychological and social services in the schools was selected. Scarborough School Board, unlike most school boards, enjoys the services of a psychiatrist who is a specialist in child psychiatry. Dr. G. Barsony spends two-thirds of his work week with the school board, of which one-half is devoted to consultations with social workers and psychologists working in the schools and one-half to consultations and workshops with classroom teachers, principals and guidance teachers. Associated with the psychiatrist are six social workers and seven psychologists. However, despite its more favourable position Scarborough School Board's psychological and social services are subject to acute pressure from the numbers problem.

In order to appreciate the precise nature of this problem, it is necessary to remember the role differentiations of the professions. The psychologists with the school board are limited by their training to diagnosis and assessment; the social workers are trained to do casework with the families of problem children and with the child himself at the level of counselling; only the psychiatrist is trained to undertake psychodiagnosis and psychotherapy. But the psychiatrist is hired to provide consultation services, and not the diagnosis and treatment of individual children. Now there are 75,000 students in the Scarborough School Board district. If we adopt the 10 per cent estimate of need, there will be 7,500 students who will need and profit from mental health services during any eleven-year period, or approximately 680 in any one year. In relation to this magnitude of need the psychological diagnostic and the social casework services are relatively adequate, although there has been a place for one more social worker for over a year which has not been filled. But psychotherapeutic services are non-existent in the school system, with the exception of some work done by Dr. Barsony above and beyond the call of duty. Consequently, the bottleneck which occurs at the first stage in the process of identification-diagnosis-treatment in Huron County is removed to the second stage in Scarborough because of the lack of psychotherapists. One could reasonably ask what is the use of diagnosis unless it is related to treatment.

Treatment resources, then, must be found in the community if the process of identification-diagnosis-treatment is to be completed — that is, if its first two stages are to be useful and meaningful. But Scarborough has only one specialist in child psychiatry, and he devotes one-third of his work week to operating a private practice. Scarborough does have a mental health clinic, but professionals with the school board stated that they no longer refer children to it. They have found that children have been returned untreated unless they are suffering from a psychosis; and very few school children who need psychotherapy fall into this category. Consequently, when seen from the point of view of treatment, and taking the greater numbers of students and the training of the professionals into account, school children in the Scarborough School Board system are not substantially better off than are those in Huron County, except for the availability of social work counselling for the children and their families based on a psychologist's assessment of the child's problem. Psychotherapy is still unavailable for child or family.

Limitations in the Role of Special Teachers

It could always be argued that psychotherapy is not the most important missing ingredient, and that what is most needed for children with learning and/or behaviour problems are classes conducted by teachers who are especially trained in teaching and controlling children with such problems. This view is not shared by experts such as Dr. Barsony. They see the purposes of the workshops and consultations that they conduct with teachers as being 1) to familiarize teachers with the diagnostic and therapeutic resources made available by modern psychiatry;

2) to improve their understanding of the genesis and symptoms of emotional disturbances and behaviour problems in children; 3) to assist them in identifying such problems in school children; 4) to encourage in them an attitude of understanding, so that they can provide the best possible kind of class and school environment for children with this handicap. It is *not*, however, the psychiatric consultant's purpose to train the teachers to be therapists, or to encourage them to attempt to establish any kind of special therapeutic relationship with an emotionally disturbed child in the classroom. The teaching and the therapeutic roles should remain differentiated. Classes conducted by special teachers are useful for the education of children with emotional and behavioural problems, but cannot substitute for treatment.

Three Possible Approaches to the Problem

There are three possible solutions: 1) expand the existing community mental health facilities and increase the number of child psychiatrists and psychotherapists (whether psychologists or social workers, or psychoanalysts) in private practice; 2) establish child guidance clinics attached to the school boards made up of skilled psychotherapists to do diagnosis, give treatment, and undertake preventive measures within the school system; 3) form comprehensive community mental health units which would provide outpatient and consultation services to the schools. Dr. Barsony is an advocate of the second option, on the grounds that it is likely to be most effective and it would generate the most educational spin-off to teachers and school officials.

A model for a child guidance clinic is the clinic in Winnipeg, Manitoba. It has a complement of forty social workers, thirty clinical psychologists, and five psychiatrists. Thus there exists a much better ratio of diagnostician, therapist and case worker to student than is available in Scarborough. For example, the Winnipeg clinic has a ratio of one clinical psychologist to every 4,000-5,000 student population, whereas the ratio for Scarborough is one clinical psychologist for every 10,000-11,000 students.

All professionals testified to the ability of teachers and principals to identify emotional and behaviour problems in children. Teachers are inadequate as far as diagnosis and therapy is concerned, but their perception of problems is excellent. Consequently the schools could function as an early warning system for preventive work in mental health, if adequate support services could be created. This study takes the position that the best support facilities would take the form of comprehensive community mental health centres backed up by private practitioners.

University Mental Health Services

All of the health services in Ontario's fifteen universities and the Royal Military College of Canada, Kingston, were sent questionnaires concerning their mental health services. Seven responded. Laurentian University reported that it was in the

process of establishing a mental health clinic on campus, but did not then have a service established. Brock University's service was at a rudimentary stage of development.

A major difference among the others was defined by their relation to the university health service and the extent to which psychologists were involved. York and Waterloo services were operated by psychologists and Western's was operated by a psychologist-physician. In all cases, patients with serious mental disorders were referred to psychiatrists in the area. This procedure is workable with OMSIP coverage for students and with the availability of psychiatrists in private practice. The York and Waterloo clinics operate in conjunction with the health service physicians, who are able to diagnose and treat any physical illnesses. Otherwise, the psychologists undertake diagnosis and treatment, usually in the form of counselling.

Ottawa, Queen's and Toronto mental health clinics are integrated with the Student Health Services. Since they are staffed by psychiatrists, the referral policies at York, Waterloo, Western and Brock are not necessary.

The University of Toronto has the largest service, but it must also serve the largest student population. The service continues to be strengthened and expanded. All degrees of illness are treated except those that require hospitalization.

During 1966-1967, the University of Toronto had 19,282 full-time students. Of these 628 were treated for mental health problems at the clinic and received a total of 3,291 treatment sessions. Of the 628, 101 had been treated in a previous year and 527 were treated for the first time. The students can be subdivided according to diagnosis as follows:

Psychosis	27
Psychoneurosis	213
Character and behaviour disorders	334
Other	54

Six hundred and twelve students were treated by individual psychotherapy and sixteen received group psychotherapy. One student was treated by psychoanalysis. Approximately 30 to 40 per cent received some medication, kept to minimal quantities and used as an adjunct to psychotherapy.

The University of Ottawa's psychiatric service is included, as is Toronto's and Queen's, in the Student Health Service. It is a very rudimentary service, staffed part time by one Fellow in psychiatry who acts as a consultant to a resident in psychiatry two hours per week. The resident also is part time and spends a total of six hours per week in the clinic.

The University of Ottawa has more than 4,000 students. Of these, twenty-seven were treated at the clinic and received a total of 105 sessions. Of these students, twenty-two were treated for the first time and five were carried over from a previous year.

The nature of these services varies considerably in terms of the period of time during which they have been operating, the type of personnel they employ, and the purposes they serve. For this reason quantified comparisons are somewhat risky and suspect, but perhaps two points can be made on the basis of the data in Table 14.6.

TABLE 14.6
Scope of Treatment for Mental Health Problems at Six Universities in Ontario

University	Percentage of student population treated during 1966-1967	Average number of services per student
Toronto	3.2	5.2
Western	2.8	2.4
Waterloo	10.8	2.9
Queen's	12.1	2.0
Brock	3.3	3.5
Ottawa	0.7	3.8

SOURCE: C. Hanly and P. Centner, *Mental Health Survey: University Health Service (Study 6)*, 1967. Based on a questionnaire survey of university clinics in Ontario.

The experience of Waterloo and Queen's suggests that Toronto could increase the scope of its service three or four times. The percentage figures for Western and Waterloo do not include psychiatric referrals. In no case does the number of treated students approach the 20 per cent figure reported by York, representing the number of students who encounter a serious personal crisis during their university career which poses a threat to their academic achievements and personal and social maturation.

On the other hand, Toronto provides much more intensive treatment as measured by the ratio of treatment to students receiving clinical service; it is almost twice that of the other universities. Furthermore, Toronto's treatment service is more intensive in terms of the duration of treatment, since almost one sixth of the students receiving treatment in the U. of T. clinic during 1966-1967 were carried over from the previous academic year. This feature of the service reflects their policy of treating all students irrespective of the magnitude of their difficulties, unless hospitalization is required.

One is struck by the extent to which the split between medical and non-medical mental health professions is reflected in these services. The services at Queen's, Western and Toronto are dominated by physicians. The services at Waterloo and York are dominated by psychologists. In the case of the latter

medical expertise is brought to bear when necessary through cooperation with doctors and through referrals to psychiatrists. This policy provides the necessary guarantees for the safety of the students being interviewed for treatment or being treated. But it is also true that many of the physicians and psychologists in these services consider that the mental health team is the most desirable kind of organization of professional resources for these services. Adherence to this concept has not been sufficiently strong, however, to bring about a distribution of psychiatrists and psychologists among the university services to provide the personnel needed to establish interdisciplinary mental health teams in the university clinics.

There are a number of specific reasons for the development of high quality mental health clinics at our universities. First, the social payoff is multiplied when students are able to use the educational, training and research resources of the universities effectively while they are there. Second, university graduates subsequently enter all the major professions, positions of leadership in industry, public life and business. Mentally healthy persons in these occupations generate secondary social benefits in many ways. Third, such clinics can provide practicum settings for the training of mental health professionals.

As in the case of other services studied, and despite the fact that six of the seven universities which responded to the questionnaire are much better served than are the other post-secondary institutions and any of the public schools, the major obstacle in the way of improving the scope and quality of the service is the shortage of properly trained men and women.

Chapter 15 The Department of Reform Institutions

Philosophy of the Department

The Department of Reform Institutions bases its policies on a philosophy of punishment, uniting components of deterrence and reform theories of punishment. Recognition of the government's responsibility to protect society from offenders by deterrence is combined with the humane realization that the most effective way of achieving that goal is through the reform of the offender. In August 1965 a Statement of Purpose was issued by the Department and announced by the Minister, the Honourable Allan Grossman, as the policy on which all programs would be based and by which future planning of the Department would be guided. The opening paragraph of this Statement reads:

The main purposes of the Department of Reform Institutions are (1) to hold in custody, for prescribed periods, those persons sentenced by the courts to its jurisdiction and (2) to attempt to modify the attitudes of those in its care, whether children or adults, to such an extent that their actions upon release will be essentially law-biding rather than law-breaking and to provide them with the kind of training and treatment that will afford them better opportunities for successful personal and social adjustment. Any programme within the department must be designed with prime emphasis on these two purposes and carried out in such a way that they are in consonance with each other.

This is a progressive philosophy. The report of the Deputy Minister of Reform Institutions, 1966, states that "prime emphasis has been placed throughout the Department on the need to modify the behaviour patterns of those in its care so that they may adopt a more useful and purposeful life in the community when released from the institutions". It is a philosophy that entails the mobilization of high quality diagnostic and therapeutic resources. It is, therefore, of some interest to consider to what extent the philosophy has been put to work.

In order to make this philosophy work, two things are needed: a psychological science and therapeutic technology; and professional personnel to apply it.

Psychoanalysis, modern psychiatry, psychology and social work go some way towards providing the science necessary for beneficially influencing the psychosocial conditions that produce the individual criminal and his crime. Professional personnel are, in principle, available; this is not to say that they are available in fact.

Adult Male Institutions

Reform institutions vary in type, so that inmates can be segregated according to age, custodial requirements, personality and behaviour problems, and rehabilitative needs.

All adult first offenders from the entire province between the ages of sixteen and twenty-four, and recidivists aged sixteen and seventeen years are first sent to the Ontario Reformatory at Guelph, where they are evaluated for placement purposes at the Reception Centre. Such evaluation takes the form of psychological testing, case histories and interviews, carried out by a psychologist. As a result of this assessment, the inmate may be sent to one of the various industrial farms, training centres, and forestry camps; or he may be retained in the Guelph Reformatory where trades training, educational programs, and general maintenance operations are offered him.

Thus, the major type of mental health service provided is that of diagnosis and assessment, for the purpose of selecting a detention environment for a sentenced person that is least likely to further impair him psychologically and which may benefit him.

Beyond the psychological assessment service of the Guelph Reformatory, the Neuropsychiatric Centre at Guelph provides special diagnostic services to prison inmates with suspected psychiatric disorders. The Neuropsychiatric Centre was established in 1955 in an attempt to improve the psychiatric services provided by the Department of Reform Institutions. It provides psychiatric examination and some short-term treatment for individuals recommended for psychological examination and treatment by magistrates. It receives referrals for diagnosis from all other reform institutions within the province. Referrals typically are made for persons with a history of psychiatric disorder, for persons who are suffering from a definite form of mental illness, for those in whom there is suspected some physical damage to the brain, or for those who are unable to adjust to prison life. The clinic, under the direction of a general practitioner, is staffed by three part-time psychiatrists and a senior psychologist, three part-time trainee psychometrists (M.A. students in psychology), and one full-time psychometrist. The actual responsibility of directing the clinic rests with the senior psychiatrist, who spends half his working time in the clinic. The other two psychiatrists each contribute one half-day per week. The service offered by the clinic is mainly diagnostic in nature. Some pharmacological therapy is done, and some group and individual psychotherapy. While formal psychiatric therapy may be performed by the psychiatrists, most of their work is in diagnosis and assessment. The clinic does not attempt to treat psychotic or psychopathic patients who are certifiable; these persons are diagnosed, certified and sent to the Institution for the Criminally Insane at Penetanguishene. This institution may reject such referrals after observation; and if they are returned to the Neuropsychiatric Clinic, they will be

sent to a provincial mental hospital or to a reform institution, whichever is appropriate. Referral to mental hospitals is particularly indicated and is usually carried out, if the offender is a young person and his crime seems to be secondary to a psychosis. As a result of improved parole service in the province, the number at the clinic who are easy to treat has been reduced, and the clinic now tends to receive only severe chronic cases. This being the case, the light temporary treatment given to prisoners during their period at the clinic cannot be viewed very seriously. In essence, the clinic is a diagnostic centre providing a referral and selection service, and temporary drug-induced palliative measures for prisoners going through a psychiatric crisis.

Efforts to inaugurate a therapeutic program in some of its institutions along the lines of the California Group Therapy System were initiated by the late V. Hartmann. Hartmann was Director of Social Work for the Department.

The program at the Guelph Reformatory was led by a social worker. He conducted sensitivity groups for selected correctional officers, who in turn conducted group counselling sessions with prison inmates.

The rationale behind the selection of custodial officers for this purpose was two-fold. First, these custodial officers represent in tangible form the authority of the institutions, since they are responsible for the day-to-day supervision of the inmates. Thus, they have added to their role as prison supervisors and guards the role of sympathetic counsellor. It is hoped that this duality of function and relationship will communicate to the prisoners — most of whom are in conflict with social authority — that persons exercising such authority are not always or necessarily hostile and may be, within the limits of reality, cooperative, sympathetic and helpful. Second, unlike most professional people, the custodial officers usually have approximately the same socio-economic experience, culture and language as the inmates. The response of both custodial officers and prisoners to the program has been encouraging to those who have developed it.

The Reformatory at Mimico has embarked on a similar scheme. Here a part-time psychiatrist acts as a consultant to the counselling correctional officers. The aim of this program is to integrate the services in the institution and to provide the inmates with someone who will listen intelligently to their problems. This counselling continues until the prerelease stage, when the inmates are referred to rehabilitation officers; these officers can be given a better understanding of the inmates they deal with through the correctional officer counsellor. Like the Guelph program, this also is voluntary. It has had a favourable reaction from the inmates and is well attended.

Millbrook Reformatory, a maximum security institution populated by disruptive inmates, sexual deviates, drug addicts, arsonists and escapees, has a capacity of 200 but has no full-time professional staff. Little treatment is offered

here, since the inmates are kept under strict supervision and exposed to a regime of physical work. Sexual deviates (pedophiles) and drug addicts are expected to receive treatment at the end of their sentence at the Alex. G. Brown Memorial Clinics, if they request such treatment and if their request is approved. The Alex. G. Brown Memorial Clinics, Mimico offer intensive inpatient treatment for alcoholism, drug addiction and sexual deviation (pedophilia). The clinics consist of three buildings with a total bed capacity of 132. There is no waiting list for services, and the patient count at the time the clinics were visited was ninety-five. The clinics are part of the adult male institutions and receive referrals from these institutions. Only in cases where patients are referred directly from the courts is treatment involuntary. On the request of an inmate for treatment at the clinics, he is first screened by the parent institution and then referred if he is found to be suitable (that is, potentially responsive to treatment). The duration of treatment for alcoholics is forty days; for drug addicts, four months; and for pedophiles, six months. The inmate who has requested and is selected for treatment spends the last period of his sentence here. On arrival, he is screened again by the clinic on his I.Q., language, social and cultural capacity, which are the criteria used in assessing his suitability for treatment. As soon as an inmate is admitted into the clinic, he is considered a patient and treated as one.

Treatment takes the form of individual counselling, group discussion, group therapy (distinguished from group discussion in its depth of involvement, in its demands for self-understanding, and in the closeness of the group), group confrontation, didactic programs, recreational therapy and behaviour modification.

The clinic is a multidiscipline setting. It does not have a clinic director, but the supervising psychologist acts as the treatment coordinator. It has a staff of five psychologists, two psychometrists, three social workers, a part-time physician and a part-time psychiatric consultant who spends four half-days in the three clinics. Other members of the staff include nurses, seven rehabilitation officers, one full-time and three part-time chaplains. The bulk of the treatment is done by the psychological staff whose work lies in the following areas: 1) in diagnostic assessment through psychological testing and interviews; 2) in case conferences which are a part of the selection procedure and in which they participate with other professions; and 3) in the disposition of the patient — that is, the placing of him in suitable treatment programs.

The psychiatric consultant provides treatment in individual psychotherapy, chemotherapy and relaxation therapy. The main responsibility of the physician is to examine the patient to see whether or not he is physically suitable for a certain work or treatment program. The role of the social workers is somewhat less clear-cut; but for the most part, they do group work and casework, and

obtain social and developmental information concerning patients. Follow-up work is considered an important part of the services offered at the clinic. This work is done by rehabilitation officers, up to a period of about a year after a patient's discharge.

Besides the three reformatories, the Department operates a number of industrial farms, training centres and camps situated in the remoter parts of the province. The emphasis of these institutions is on vocational training, farming and forestry work, combined with some academic training. There are neither full-time nor part-time professional staff, with the exception of perhaps a physician in two or three places.

TABLE 15.1
Treatment Facilities and Personnel in Adult Male Institutions

Brampton OTC		
	<i>Full time:</i>	1 Social Worker 1 Social Worker Assistant
Guelph NPC		
	<i>Casual:</i>	4 Psychiatrists 2 Psychometrists 1 Student Psychometrist
	<i>Full time:</i>	2 Psychologists 2 Psychometrists 1 Social Worker
Millbrook OR		
	<i>Casual:</i>	1 Psychiatrist 1 Psychologist 1 Social Worker/Chaplain 1 Assistant Social Worker
Mimico Clinics		
	<i>Casual:</i>	2 Psychiatrists 1 Psychometrist 1 Assistant Social Worker
	<i>Full time:</i>	1 Psychiatrist 5 Psychologists 1 Psychometrist 2 Social Workers
Mimico OR		
	<i>Casual:</i>	1 Psychiatrist 1 Psychometrist

Thus, apart from the Alex. G. Brown Memorial Clinics, the therapeutic resources of the Department's institutions are meagre — so meagre, indeed, that the rehabilitation philosophy of the Department must be considered little better than sincere rhetoric. Professional personnel working closely with prisoners and observing the impact of imprisonment on them stated in field interviews that such diagnostic and treatment services as are available can, at best, be expected to minimize the adverse effects of imprisonment on the mental health of prisoners, in the hope that on completing their sentences, they will be able to find resources for their psychological and social rehabilitation. Some of the effects of imprisonment on offenders are 1) precipitation of psychotic states; 2) sexual regression to homosexuality; 3) depression to the point of preoccupation with suicide and attempts at suicide. These harmful and dangerous psychopathological states require expert treatment. The most that the professional personnel in most institutions can do is to inaugurate temporary steps to reduce their worst effects, and to try to protect the prisoner against permanent psychological damage.

Professional Resources

The difficulties in which these institutions find themselves have two sources. The technical therapeutic problems presented by the psychological rehabilitation of offenders are immense, and the environment of the institutions is not conducive to solving them. Consequently, the best quality professional resources are needed. However, professional resources of any kind are difficult to obtain in this field.

Table 15.1 summarizes these resources in a number of key institutions. There is every indication that this situation will continue unless new solutions are found. It is very unlikely that intensification of past procedures will have any effect. The effort to develop group counselling utilizing subprofessional resources is a welcome ray of hope. It is unclear as yet how stable and how effective this program will prove to be.

Adult Female Institutions

At present, there are two institutions for women: the Mercer Reformatory and the nearby Ontario Guidance Centre. Every female offender is first admitted to the Mercer Reformatory, where she receives a medical examination and is subjected to the same procedure of evaluation and assessment used in male institutions. The difference is that here there is little to be discussed on the subject of placement, since the guidance centre is only a very small adjacent unit and the majority of the inmates are kept at the reformatory. The case conference is more important for purposes of planning work, education and treatment programs for the inmates than for determining suitable placement.

In certain respects, the female institutions are better off than the male institutions. In the first place, there are fewer female offenders. The ratio of female to male inmates in custody during 1966 was approximately 1 to 15.3. Second,

almost all female inmates are kept in one place. This policy reduces some of the administrative and staffing problems which male institutions have to face. Consequently, female institutions have better services and often are pioneers in the implementation of changes and experiments in treatment programs. Finally, while in the male institutions administration and custody are separated from therapeutic services, in the female institutions they are integrated. This integration is due not only to the closeness of the administrative staff to every member of the professional and custodial staff and to the inmate population, but also to the presence of a professionally trained administrative staff. The administrator is a psychiatric social worker by training; the superintendent is an M.S.W., and deputy superintendent is a psychiatric nurse with a B.Sc.N. degree. Professional staff at the two institutions include two part-time psychiatrists who spend four half-days per week and three half-days per week, respectively, here; one psychometrist occupying a Ph.D. psychologist post; and two social workers. The strong social work bias may be responsible for the principle of environmental treatment which is emphasized in all the programs conducted in the institutions.

Perhaps most significantly, the integration of administration and treatment services through the appointment of qualified mental health professionals to senior administrative posts reflects the recognition that criminality is not an accident of volition but the behavioural consequence of a personality disorder. This point of view, acknowledged explicitly by the superintendent, guides the formation of administrative and treatment policy. Efforts are made to design all aspects of the institution to function as a "therapeutic community", challenging and, if possible, resolving the character and behaviour problems of the inmates while supporting and encouraging whatever strengths they may have.

More specialized treatment takes the form of group counselling sessions conducted by non-professional staff and group psychotherapy conducted by professional consultants (psychiatrists or psychiatric social workers).

The Mercer Reformatory has been replaced recently by the Vanier Institution, Brampton. Despite the comparatively favourable situation of this female institution chronic professional manpower shortages make it imperative that the treatment philosophy of the institution should place the greatest emphasis on the "therapeutic community", which utilizes professions almost entirely as consultants to correctional staff who become responsible for carrying out such therapy as is available.

Training Schools

There are thirteen training schools in the province: six non-denominational schools for boys and four for girls, and two additional schools for boys and one for girls operated by Roman Catholic Orders. Although the program in each school is designed to meet the needs of the particular children admitted to its

care, academic, vocational and recreational training as well as spiritual and psychological counselling also are provided. The same procedure and method in classification for placement in adult institutions is employed here: first, by analyzing the problem presented by each child through the use of social histories, medical, psychiatric and psychological examinations; and second, by deciding in staff conferences on a program of treatment and training based on these analyses. Classification takes place at the Reception and Diagnostic Centre for Girls, Galt, and at the Reception and Diagnostic Centre for Boys, Bowmanville. The average length of stay is between two and three weeks.

The operation of the training schools is based on the Training Schools Act, 1965 which states that the purpose of a training school shall be "to provide the children therein with training and treatment and with moral, physical, academic and vocational education". The aim of the schools is, therefore, to provide a climate in which children may be helped to modify their attitudes towards other people, towards themselves, and towards society, in such a way that their behaviour can become more socially acceptable. As we interviewed none of the staff and visited none of the schools, we can say little about the prevalence and treatment of mental disorders among the children in the schools, except whatever can be deduced from Table 15.2 on professional personnel.

TABLE 15.2

Treatment Facilities and Personnel in Training Schools

BOYS' SCHOOLS:

Pine Ridge School, Bowmanville — Reception and Diagnostic Centre

Casual:	1 psychiatrist
	1 psychometrist
	1 speech pathologist
Full-time	1 guidance teacher

Brookside School, Cobourg

Casual:	1 psychiatrist
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Sprucedale School and White Oaks Village, Hagersville

Full-time	1 social worker
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Glendale School, Simcoe

Casual:	1 psychiatrist
Full-time	1 psychometrist

Hillcrest School, Guelph

Casual:	1 psychiatrist
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TABLE 15.2 (Continued)**GIRLS' SCHOOLS:****Reception and Diagnostic Centre and Grand View School, Galt**

Casual:	3 psychiatrists 2 psychologists 1 social worker
Full-time	1 psychologist 2 psychometrists

(8 University of Waterloo students proceeding towards their Ph.D. in psychology involved in various research projects at the treatment unit).

Kawartha Lakes School, Lindsay

Casual:	1 psychologist
Full-time	1 psychometrist

Trelawney House, Port Bolster

Nil

PRIVATE TRAINING SCHOOLS**St. Euphrasia's School, Toronto**

Casual:	2 psychiatrists 1 psychologist 2 social workers
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St. John's School, Uxbridge

Casual:	1 psychiatrist
Full-time	1 psychologist 1 social worker

St. Joseph's School, Alfred

Casual:	1 psychiatrist
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Jails

In January 1968, the Department of Reform Institutions assumed responsibility for the administration of the thirty-four county jails and two city jails with a total population of 53,512 male and 4,718 female inmates (1966). As this administrative change has occurred recently, there is little information available on the treatment facilities and personnel provided for inmates.

A General Consideration of Treatment Resources

The section of the Department of Reform Institutions responsible for Treatment Services is comprised of members of the different disciplines of psychiatry, psychology and social work. To these, medical and chaplaincy services also may

be added. The critical shortage of manpower can be evidenced by the fact that, when interviews were conducted in 1968, the posts of Director of Psychiatry and Director of Social Work were both vacant and were held temporarily by the Director of Psychology, who came into the Department in September 1967.

As we have seen, no institutions within the system are able to attract the services of a full-time psychiatrist. The design and execution of treatment programs, especially in psychotherapy, will continue to suffer unless and until other professionals acquire skills in psychotherapy. Although forensic psychiatry ranks reasonably well as a major interest of Ontario psychiatrists (Table 4.4), the role of psychiatry is likely to be limited indefinitely to providing consultations.

Given the emphasis placed on diagnosis and referral, traditional clinical psychology and psychometry can play an important role. Indeed, psychologists are the largest single professional group in the service. In spite of this, the Department is having great difficulty in the recruitment of adequate workers to fill the existing posts. As mentioned earlier, of the twenty-four posts for full-time Ph.D. psychologists in the Department, at the time of writing eight were filled by Ph.D.'s, eight were held by psychometrists, while eight were vacant. The qualifications set down by the Civil Service Commission for the post of psychologist is a Ph.D. and registration with the Ontario Board of Examiners in Psychology or qualifications of similar standing (an applicant with an M.A. and several years of experience would qualify for registration). In order to improve the services available to inmates, it is necessary to have sufficient number of psychologists of the right calibre. The Director of Psychology believes that such people could be attracted to the field if salaries were increased to a level competitive with those offered elsewhere.

Psychologists (or rather, psychological staff, as psychometrists also are included under the term) are involved in both assessment work and treatment in the various institutions. The responsibilities of each psychologist differ from institution to institution because of the differences in the nature and number of the inmate population. At Mimico, for example, psychologists are engaged more in treatment than in assessment, whereas in the Reception Centre at Guelph the greater portion of their tasks is carrying out tests and appraisals. Treatment by psychologists in the institutions takes all the varied forms which are to be found in other clinical settings: counselling, group therapy, group and individual psychotherapy, and behaviour therapy. The Director stated, in a field interview, that there is no way of measuring the successes and failures of these treatment methods.

The shortage of social workers is even somewhat greater than that of psychologists.

In general, professional resources are in a chronic state of short supply throughout the system at all levels.

Problems of Professional Resources Peculiar to Reform Institutions

There are major manpower shortages in every sector of mental health. But reform institutions have problems of their own. The institutions are more depressing to work in than the Ontario Hospitals. The persons to be treated present some of the severest character and behaviour disorders. Funds are not available for research. The institutions are often located in areas where professional resources are especially scarce. The accumulated result of these factors is a general mood of pessimism.

The view held by the Assistant to the Administrator of Adult Male Institutions appears to sum up the whole situation in reform institutions. He has remarked that the Department of Reform Institutions does not have adequate professional staff to deal with the mental health problems of the inmates, nor are there adequate resources available outside the Department on which it can rely for the treatment services it needs in order to achieve its objective of reform. It is true that a number of programs are being carried on in different reformatories. By and large, however, the professionals involved in providing them do not think that they are sufficient, or as successful as they could be with more professional resources available. It is not difficult to provide rather impressive statistics for annual reports which may satisfy the general public and the politicians; it is more difficult for the professionals in these services to satisfy themselves that the first purpose of their work — the reform of offenders — is being achieved.

Whether or not one considers the present treatment facilities and personnel to be adequate depends entirely on the philosophy one holds on the treatment of offenders. Some feel that there is still strong pressure in favour of retributive custodial policies within the Department, in spite of the Statement of Purpose adopted by the Department. These forces make it difficult to progress towards adequate facilities to rehabilitate inmates and help them back on the road to normal functioning in society.

The importance of treatment facilities for inmates of correctional facilities cannot be exaggerated, as long as the Department and the public want its reformatory objective to be taken seriously. The development of psychological and psychiatric diagnostic services is necessary and useful for three specific purposes: 1) for presentencing reports concerning the offender, to assist judges in passing sentences; 2) for rational planning of the inmates' custodial situation and program; 3) for handling the severely disturbed psychotic and sociopathic inmate who need certification to Penetang or to a mental hospital. The usefulness of diagnosis stops at stage 1), however, and falls short of providing the basis for an adequate treatment program aimed at reform unless there are fully developed well-staffed treatment services.

Bureaucratic and Political Responses to Inadequate Resources

No one should be encouraged to think that the solution to this problem is easy. However, the Department has not always taken steps that will make it any easier. Recently the Department has come under attack for the lack of adequate diagnostic services to the courts. The response to this demand has been more bureaucratic and political than constructive. The Department has decided to construct a large building costing several millions to house a provincial diagnostic service. The problem inherent in this approach is made perfectly clear by the findings of this report: it is relatively easy to erect physical facilities and acquire secretarial, administrative and custodial staff for it, but how will the necessary professional staff be recruited? Buildings are visible to the public and may generate the conviction that effective measures have been taken to achieve the reformatory purposes of our prison system. But might it not be much more effective to invest the money spent on a new institution in training programs to prepare the diagnosticians and therapists needed by the Department's services?

Three Possible Approaches to the Problem

There are, moreover, three quite different concepts according to which mental health services for the Department of Reform Institutions could be developed. One is to have all diagnostic and treatment services needed by the Department located within the Department. Another is to have some of these services operated by the Department itself, while others are provided by independent institutions and agencies (for example, by Ontario Hospitals or by private practitioners). The third is to have all diagnostic and treatment services provided by agencies external to the Department.

There are at least two decisive objections to the third concept. The Department has to have sufficient diagnostic and treatment resources in order to handle emergencies and to provide basic services intrinsic to the effective working of its institution (such as diagnostic services for placement, and the development of group counselling and other programs within the institutions). There is a need for the direct influence of full-time mental health professionals within all aspects of the Department's operation in order to support a constructive atmosphere and to provide close liaison with other external mental health services.

Given the difficulty of recruiting needed mental health professionals, however — a difficulty which will increase rather than abate in the future — the second concept may offer the best guide to long-term resource planning. If many more psychiatrists, psychologists and social workers were trained and in practice in various extradepartmental services, from private practice to community clinics, then the courts and reform institutions presumably would have access to diagnostic and treatment services from external sources.

The particular advantage of this concept is that it could circumvent the difficulty of attracting mental health professionals to the services of the Department of Reform Institutions on a full-time basis. If there were a network of community mental health clinics throughout the provinces in which professionals could work together on a wide range of problems, three difficulties that now plague recruitment could be overcome. These difficulties are professional isolation; work in a custodial setting; and work with prison inmates only. The potential difficulty inherent in this approach for the Department of Reform Institutions is that, unless appropriate guarantees were established, the community mental health clinics might fail to provide needed service through lack of interest or through their commitment to other service priorities. However, an interdepartmental program involving the Department of Health, the Attorney-General and the Department of Reform Institutions could provide the necessary guarantees and comprehensive interrelated planning of services necessary to make such a concept work. It would also have the great advantages of decentralizing the accumulation of professional resources in a few large cities, and decentralizing the bureaucratic structures that are rapidly generating a multitude of managers with large staffs without growth in direct service. The growth is, after all, the only proper end to be realized and the only justification for a managerial bureaucracy.

But the most important feature of a system in which the courts and reform institutions are linked to well-developed comprehensive community mental health centres is the preventive work that can be done. Every senior mental health professional interviewed emphasized the paramount importance of prevention. By the time an individual has been imprisoned for a criminal offence, most of the best opportunities for prevention through reform have already been lost. A comprehensive community mental health centre would have the advantage of being able to coordinate the efforts of ancillary community agencies and to link the courts, the schools and the families concerned to an effective diagnostic service and sound therapeutic programs.

The "Open Prison" Policy

The Department of Reform Institutions has embarked recently on a new "open prison" policy. This policy makes it practical for prison inmates with mental health problems to regularly attend a community mental health clinic, as long as planning for the location of these clinics and the location of reform institutions can be coordinated. Since the Department has assumed responsibility for county jails, these jails could be modernized and used as institutions for the custody of offenders who could benefit from regular attendance at a community clinic. Thus potential exists for relatively inexpensive, decentralized, small units in conjunction with and in proximity to mental health clinics which could provide therapeutic services for the reform of criminals.

The deployment of professional resources in this way will solve numerous problems inherent in the existing system. It will also prove to be more effective, by reducing duplication, and by locating problems where they arise and where they must be solved—in the communities. There is only one basic difficulty with this concept. At present no comprehensive community mental health clinics exist.

Chapter 16 Alcoholism and Drug Addiction Research Foundation (ADARF)

The Scope of the Problem

The problem of human dependence on chemicals — alcohol and other narcotic drugs — which have a detrimental effect on personal health and behaviour is a problem of considerable magnitude in the province. Estimates of alcoholism prevalence obtained by means of the Jellinek formula, based on the number of deaths from cirrhosis of the liver in 1965, give a total of 100,120 alcoholics in 1964, while the officially recorded prevalence of narcotic addiction for 1966 was 953.¹ If the total population of alcoholics increases by about 6 per cent of the prevalence estimate each year,² the number of alcoholics for 1966 would be 112,495, bringing the total of alcohol and drug dependent persons to 113,448 for the same year. If we examine this problem in relation to other mental health problems by comparing this number to the total mental hospital population (22,123 including those in approved homes and those on probation),³ we can appreciate the seriousness of the situation. The magnitude of this problem alone makes it extremely difficult to manage and, given the professional resources that we have today, many addicts, especially alcoholics, will have to go without significant treatment of any kind.

A study of the treatment of alcoholics in relation to mental health resources in Ontario has been made by Reginald G. Smart of ADARF. Basing his calculations on a recovery rate of 33 per cent of all patients treated, he estimated that if 10 per cent of all physicians, social workers and psychologists were to work full time in the treatment of alcoholics, the annual decrease of the alcoholic population would amount to 11.6 per cent — a reduction of 8.3 per cent by physicians, 2.3 per cent by social workers, and one per cent by psychologists. But since the annual increase of the population of alcoholics is 6 per cent, this would mean that an annual reduction of only 5.6 per cent could in fact be achieved. Even this calculation is utopian, since it is not realistic to expect that 33 per cent of patients treated would be “cured” or that as many as 10 per cent of all professional workers would be engaged in full-time work in this field.

¹ADARF 16th Annual Report, 1966, Appendix III: Statistics of Alcohol Use, Alcoholism, and Drug Addiction in Canada and Its Provinces.

²Reginald G. Smart, *Mental Health and the Treatment of Alcoholics in Ontario*, ADARF.

³Figures for December 31, 1965, 99th Annual Report, Mental Health Division, Ontario Department of Health.

According to another source of information, it has been estimated that only about 10 per cent of the alcoholics in any community have ever been under treatment of any kind, whether in a clinic, through their own doctor, or through Alcoholics Anonymous. This estimate disregards the degree of benefit derived from that treatment.⁴

The professional manpower shortage is not the only obstacle to successful treatment in this field. There are two other important factors. The first is a lack of recognized treatment methods, because there is relatively little concrete knowledge about the nature of alcoholism and addiction. A number of approaches currently are used in treatment, and the approach selected in each case depends on whether the therapist considers addiction to be a medical, a psychiatric, or a social problem. No proof exists that one approach is more effective than another. The second factor is difficulty in identifying cases and sending them to treatment, because of the basic unwillingness of many alcoholics to recognize themselves as such.

History and Organization of ADARF

Because of this situation, the existing facilities provided by individual therapists, hospitals and clinics could not be expected to deal with alcoholism and drug addiction without the aid of a concentrated and coordinated research program. The Alcoholism and Drug Addiction Research Foundation, established in 1949 as an experimental unit to conduct research, treatment and educational programs in this field, is an organization designed to fulfil this function. Under its legislative terms of reference, ADARF is empowered

- 1) to conduct and promote a program of research in alcoholism and addiction; and
- 2) to conduct, direct and promote programs for
 - a) the treatment of alcoholics and addicts,
 - b) the rehabilitation of alcoholics and addicts,
 - c) experimentation in methods of treating and rehabilitating alcoholics and addicts, and
 - d) dissemination of information respecting the recognition, prevention, and treatment of alcoholism and addiction.

The Foundation is supposed to play a leading role in prevention and control; education and information; early detection, treatment and rehabilitation; and research in cooperation with other government and private organizations, and agencies of Ontario.

⁴John D. Armstrong, "Alcoholism — A Social Dilemma", *The Journal of Social Therapy*, 3rd Quarter, Vol. 5, No. 3, 1959.

Major Functions

Professional Training

In Toronto experimental treatment units have been established which play a leading role in the development of clinical techniques and in the training of clinical personnel for the province. Plans also have been made for the establishment of similar but smaller treatment-training institutions within universities or hospitals in various cities, usually where university medical schools exist. In addition, professional training is conducted within the Foundation's various regional units in London, Toronto and Ottawa. This training takes the form of periods spent in ADARF clinics by undergraduates in medicine, social work, and related disciplines. Apart from student training, ADARF also provides opportunities for refresher training for the mental health professions through short seminars, courses and lectures. A summer course, co-sponsored each year by a major Ontario university, is offered to members of the professions who are in a position to influence policy and practices with respect to alcohol and drug-related problems throughout the province.

Services to Industry and Other Employers

Research indicates that about half of the alcoholics in Ontario are fully employed. Rehabilitation results are approximately twice as good with employed patients as with unemployed. The Foundation provides programs to encourage the early recognition and referral of problem drinkers within employed groups. This is done through seminars for management and senior staff of industrial companies, assistance given by ADARF industrial consultants to company personnel in the formulation of policies and training programs, and the establishment of rehabilitation programs for alcoholics. Action will be taken also to encourage provincial and federal government departments, and Ontario Federation of Labour officials and affiliated unions to set up similar seminars for appropriate personnel.

Assistance to Other Treatment and Rehabilitation Programs

In 1966 six independent organizations were selected to receive grants-in-aid for rehabilitation projects from the Foundation. The organizations selected were

- 1) Half-way houses for recovering alcoholics:
 Wayside House (Hamilton)
 Bold Park Lodge (Hamilton)
- 2) Rural treatment centres:
 Hidden Springs Centre (Brantford)
 Hope Acres (Glencairn)
 Southdown (Aurora)
- 3) Street Haven (Toronto)
 (a reception centre for female drug addicts)

In addition, the Foundation supports clinical and laboratory work in university and hospital settings through a system of research grants and fellowships for selected persons working in this area.

Research

Research is done at several levels, including treatment methods, the biochemistry of addiction, social and psychological factors in addiction, and epidemiology.

Education

The educational program is aimed at youth through the inclusion of drug and alcohol education in the curriculum of the Ontario Department of Education; the education of parents through the medium of newspaper advertising, through its publications and other presentations; and the education of the general public through publications distributed by the Foundation.

Summary Comment

Direct services to addicts are, therefore, but a small part of the function of the ADARF which hopes to play a leading and a coordinating role for all available facilities in the treatment and rehabilitation of addicts. In the more densely populated areas of the province, the Foundation has set up specialized treatment centres for alcoholics. These are intended to demonstrate to others how to help alcoholics. In the more remote regions, where the Foundation's centres have been set up only recently, the staff of the Foundation endeavours to provide diagnostic, referral, consultative and coordinating services with an aim to mobilize the maximum of available local health and social services, and to act as a liaison between medical services and social services on behalf of alcoholics. It is the official policy of the Foundation that each region should be as autonomous as possible in deciding the approaches that are to be adopted towards the provisions of services.

Work of Regional Units

Toronto Clinical Services

Outpatient services are provided at two clinics: the Central Toronto Outpatient Clinic and East Toronto Branch.

The Toronto Outpatient Clinic treats more patients per year than any other single unit of the Foundation. Approximately 20 per cent of the patients have problems with drugs other than alcohol. While alcoholism is still the main concern of this clinic, it includes within its staff two specialized clinical research teams, one concerned with narcotics of the opiate type and the other with marijuana. The director is an internist. The chief person in the diagnostic process and the allocation of cases for treatment is the physician to whom the patient is first directed. Treatment is based on psychotherapy, which is practised by both the physicians and the social workers. The clinic has one psychologist who plays a routine part in diagnosis but no part in treatment.

The East Toronto Branch is an outpatient clinic which serves suburban residential and industrial areas. The Acting Director of the clinic is a pastoral counsellor who heads a small staff consisting primarily of social workers and public health nurses. As there is no physician on staff, medical services are provided by a part-time consultant psychiatrist. The major type of treatment here also is psychotherapy. An attempt is made to involve the spouse and, frequently, the children of the patient in treatment.

In addition to the two clinics, a day care centre provides psychiatrically oriented treatment for selected patients who are able to attend its program five days a week for seven weeks, but who do not require hospitalization. The small staff of the clinic is headed by a psychiatrist. Patients are selected from other ADARF clinics on the basis of good education, fair socio-economic status, prognosis, and their ability to respond to the kind of treatment offered at the centre. Because of the careful screening of potential patients, the success rate in treatment is quite high.

Inpatient services are provided at the Acute Treatment Unit, the Continuing Care Unit and the Hastings Building in the Riverdale Hospital complex.

The Acute Treatment Unit specializes in the medical management of withdrawal problems. About 90 per cent of its case load are patients with acute alcohol withdrawal problems, the remaining 10 per cent having problems related to various other drugs.

The Continuing Care Unit provides five to six weeks of intensive residential treatment for selected patients. It is psychiatrically oriented and deals for the most part with patients referred to it by other ADARF outpatient units.

The Hastings Building in the Riverdale Hospital complex has thirty-five beds for the treatment and investigation of the acutely ill alcoholic. This is essentially a research hospital for studying the physical complications which accompany alcoholism.

Rehabilitation services include a half-way house in Toronto, a rehabilitation farm in Elora, and a recreational club. The former two are experimental units, while the club is an independent activity run by patients and ex-patients in a house provided by the Foundation. It provides much-needed social support for persons recovering from alcoholism.

Hamilton Metropolitan Region

In addition to the activities in research and education described earlier, the Hamilton Region offers direct services at the Dundurn Clinic. This clinic also plays a collaborating role among other hospitals, agencies and services of the area. The clinic treats only alcoholics, all drug addicts being referred to the

Central Toronto Outpatient Clinic. The orientation of the clinic is almost exclusively medical, since the Director is a physician and the staff consists of four other physicians and five nurses. There is one consultant psychiatrist, but there are no psychologists. The clinic was without a social worker for a year until the recent recruitment of two social workers. The major emphasis in treatment is that of individual therapy in the form of medication and some counselling, although a small number of patients are engaged in group counselling. Family group therapy in selected cases also has been initiated by the consultant psychiatrist. Although the Director does not see a compelling need for psychiatry in the treatment of addiction, like most people in the field she is ready to accept any contribution which any discipline can offer to overcome the considerable gaps in knowledge concerning addiction.

Lake Erie Region (London)

The Director is a psychologist. He believes that alcoholism is a maladaptive way of life, and that the distinctive characteristic of one who suffers from it is his unwillingness and/or inability to be responsible for his conduct. The patient population is divided into two groups. In the first group, comprising the majority of the case load, are those who are capable of exercising some degree of responsibility and who can be helped to modify their approach to life through outpatient facilities; a few among them may need a period of medical treatment in hospitals. In the second group, comprising 10-15 per cent of the case load, are those who are only nominally accountable for their conduct and would receive little benefit from an outpatient clinic. For both groups, recovery depends on the individual's ability to modify his approach to life. The function of the clinic is to undertake with patients a program of education or re-education to this end. The emphasis in treatment is on group therapy conducted mainly by social workers. The spouse, the employer, or any other significant person or organization in the patient's life also is involved in these sessions whenever feasible.

The activities of community development and education, professional training and research are being carried out in this region by the clinic.

Eastern Ontario Region (Ottawa)

The Regional Director is a professional social worker. Except for three physicians and a consultant psychiatrist, the staff consists almost entirely of social workers. This fact is reflected in the treatment programs, which are mainly in the form of group therapy conducted by the social workers.

The clinic has a treatment-consultation team which provides case consultation and clinical assessment to other disciplines, such as nurses, physicians, clergy, social workers and probation officers. There is close liaison with the medical, social work, and nursing staff of the Ontario Hospital, Brockville, which has resulted in an expansion of inpatient services and follow-up care for hospitalized alcoholics.

Another example of community resource development is the growth of the Ontario Probation Services Youth Counselling Program initiated in 1965. Under this program, young people convicted under the Liquor Control Act are now being placed on Probation by Magistrates in Ottawa and Cornwall. A series of six weekly discussion groups are held for these young people, involving the cooperation of the Probation Service staff, the ADARF staff, and community leaders from AA, business, and the clergy.

*Northwestern Ontario Region, Northeastern Ontario Region,
Lake St. Clair Region and Midwestern Ontario Region*

These units have been established recently. They are much smaller than the others in the size of their staff and in the number of patients. The work done in these regions is more of an exploratory nature, with one or two of the Foundation's staff being posted there to carry out surveys and organizational work or to provide diagnostic, referral, consultation and coordinating services to other community health and social services.

Summary and Conclusions

The work of ADARF by no means solves all the problems of alcoholism and drug addiction. In 1966 only 4,710 patients were given treatment at its clinics, irrespective of benefits derived. This total makes up only slightly more than 4 per cent of alcoholics and drug addicts in the province for the same year.

There is no reason to believe that the percentage of patients treated will increase very much in the near future. The only comfort to be derived is that this figure represents only the amount of direct services rendered by the Foundation, and does not include what might be achieved in its program of community education, prevention, professional training and coordination of other services. But these additional efforts notwithstanding, prospects are not at all promising for the effective treatment of addicts. The severe shortage of mental health professionals has already been established. Any planned improvements in the treatment of alcoholic and drug addicts in the province are likely to be hamstrung by this fact.

Proposal for Training Non-professional Counsellor/Therapists

One suggested remedy for the manpower problem made by Reginald Smart of ADARF is to train non-professionals to give psychotherapy to alcoholics and to have them work under the supervision of more highly trained professionals. These workers would receive intensive training in psychotherapy with alcoholics alone, rather than in more theoretical aspects of diagnosis and etiology. Similar suggestions have been made for increasing the manpower force to deal with other mental health problems. A number of experimental programs have been carried out in the United States, showing that trained persons, regardless of background, can bring about major behavioural and personality improvements in mentally ill

persons, assuming that the illness is not a psychosis. The advantage in this approach is that if non-professionals are used, new personnel will be added to existing resources. A major difficulty in the implementation of such training programs is the opposition from established professions to using non-professionals to administer psychotherapy. This opposition is particularly strong from medical practitioners, some of whom object to the administration of psychotherapy not only by non-professionals, but also by non-medical professionals.

Without an imaginative and constructive approach to the problem of preparing new treatment personnel to man these services, however, our society is going to be left in the position of providing fairly adequate diagnostic services to our population of addicts, and altogether inadequate treatment services. The real bottleneck in every service — and drug addiction services are no exception — is moving a patient from diagnosis into a treatment program that has a reasonable prospect of benefiting him.

Chapter 17 Family Service Agencies

General Background

In this report some emphasis has been placed on the need for greater community involvement in mental health. Community psychiatry adopts this emphasis as an essential component of its treatment strategy. It is useful at this stage to consider voluntary community resources as expressed in community family service agencies.

Family service agencies are private voluntary agencies which offer professional counselling to families and individuals under stress. According to the list provided by the Ontario Welfare Council, in 1967 there were twenty such agencies operating in Ontario. Of these, six were Catholic agencies, two were Jewish, and the remainder were non-denominational. They were located as follows:

4 in Toronto	1 in Oakville
3 in Hamilton	1 in Peterborough
2 in Ottawa	1 in Cornwall
2 in London	1 in Sarnia
2 in Windsor	1 in Kitchener
1 in Brantford	1 in Galt

The agencies are financed primarily by United Appeal funds with a small fraction of their income generated by fees for their services. A number of these agencies do not charge fees at all. Those which do, charge fees according to a per interview sliding scale which is adjusted to the gross income of the family. Those who fall below the range covered by the scale and those who, for special reasons, are unable to pay are asked to pay a token fee instead. There is no fixed scale established for all the agencies, but there is not much difference from one agency to another. Usually, where the combined gross monthly income of the family is \$400, the fee for one interview is \$4.00; where the monthly income is \$500, the fee is \$5.00, and so on. There is no charge for the initial interview. Judging from the annual financial statements of these agencies and from information obtained during interviews, the fees derived form only from 0.5 per cent to 5 per cent of the total income of each agency. From this fact it is not difficult to surmise from which economic stratum the majority of their clients come.

Financial Problems of Volunteer Agencies

A number of agencies have expressed concern over their precarious financial situation. While funds from the United Appeal to each agency have not been

reduced, there are no means by which agencies can increase their funds to expand their services and add to their staff to meet growing needs.

The number of member agencies sponsored by the United Appeal has been increasing. Consequently, even with increased public support it is not possible to increase grants to individual agencies. Moreover, because of the dual movements of government-supported hospital services going into the community and of government, in the form of local public welfare departments entering fields which were traditionally the jurisdiction of the private agencies, people begin to question the need to support the community agencies in their fund-raising campaigns.

The problem is that these tax-supported services often do not benefit the people who make use of the services of the family service agencies, and therefore do not help to ease their work load. The socio-economic distribution of expert psychiatric services as determined by our OMSIP diagnostic data study confirms this fact (Table 5.11). These are the people who are in need of professional help but whose needs are covered neither by public welfare nor by hospitals. Their difficulties and problems affect their lives and the lives of those they relate to, but they are not ill enough to benefit from either inpatient or outpatient hospital care. They may not be poor enough to be on welfare, but they are poor enough to be unable to afford the services of a private psychiatrist or psychologist. Or they may be people who are already on welfare but who find that a host of problems, including mental health problems, remain unsolved.

The Role of Family Service Agencies

Although family service agencies are not concerned primarily with the diagnosis and treatment of mental illnesses and do not regard themselves as a mental health service, they would not hesitate to say that they are directly involved in, or at least supportive of, mental health and that their programs include some mental health goals and purposes. According to the Statement authorized by the Board of Directors, Family Service Association of America, November 1963:

The family is society's basic bulwark for the mental health of its members and the family service agency with its casework and counselling is a basic mental health resource.

Through family-centred counselling, these agencies identify emotional problems and early symptoms of mental illness, help family members cope with dangerous stress, treat problems of individual and social maladjustment when required, and prepare individual family members for psychiatric care.

The Nature of their Services

Sources of Referral

A wide range of problems is brought to the doors of family service agencies, partly because there are many sources of referral which direct clients to them. A

questionnaire which was sent to all administrators of social work agencies and departments was sent also to family service agencies. The replies from the seven agencies to whom the question of sources of referral was put provide the averages given in Table 17.1.

TABLE 17.1
Sources of Referral of Clients to Seven Family Service Agencies in Ontario

Sources of referral	Percentage of total no. of applications
Health and welfare	21
Churches and schools	11
Professional practitioners	4
Individual and publicity	39
Other	25

SOURCE: C. Hanly, J. Wong and M. Landauer, 1967. Data derives from a questionnaire to administrators of seven family service agencies in Ontario.

"Health and welfare" includes all public health facilities such as general hospitals and clinics, psychiatric facilities, community service agencies, departments of public welfare, and the courts. "Professional practitioners" includes private physicians, lawyers and other professional practitioners. "Individual and publicity" includes former clients, neighbours, relatives, friends, self referrals, and publicity through advertisements on radio and television, and listings in telephone books. "Other" covers a wide area including industrial, commercial and labour establishments.

Many of these applications for help do not fall within the scope of the responsibility of the agencies. The problem of "inappropriate referrals" was raised with eight agencies. Four of them did not find inappropriate referrals to be a problem because they amounted to only 3 to 5 per cent of their applications. The other four agencies, however, found that too much of their staff time is taken up with such referrals. In some cases, these people have to be turned down; in others the agencies find the appropriate services and resources for them. In one agency, this work took as much as 25 per cent of staff time.

These agencies cited three reasons contributing to the frequency of inappropriate referrals:

- 1) The public is insufficiently informed as to the functions of family service agencies.
- 2) There is no place (for example, an information centre) where information on various community resources could be obtained.
- 3) There is a shortage of health and welfare facilities and a lack of emergency services to provide first aid to people in all kinds of distress.

The people who make inappropriate applications are

- 1) Those who are in need of other professional help, often psychiatric and legal help in cases of divorce and marriage breakdown.
- 2) Those who are suffering from major psychiatric difficulties which cannot be handled on a consultation basis.
- 3) Those who are in need of financial aid.
- 4) Those who have been discharged from mental hospitals, who are unable to function on their own in the community but are nevertheless left alone because of either a lack of supervised boarding homes or a lack of help given them by such homes.

Primary Areas of Assistance

These agencies focus their attention on the following types of problems: marital conflicts; disturbed parent-child relationships and family strains which appear between members of different generations; individual personality and adjustment problems, such as fears of insecurity growing out of job, family or other social relationships; and financial problems of persons who need help in more efficient management of their finances and budget planning. In addition there are problems of addiction (usually alcoholism), unwed parenthood, adoption, adolescent maladjustment, physical illness and handicap, mental disturbance and retardation, and so on. Clients also bring problems which are essentially environmental in nature, such as housing, employment and debt. In many cases, these environmental problems are associated with psychological symptoms and disturbed family relationships.

Of the eight agencies visited, five stated that marital problems are most frequently encountered and occupy about half of their case load. Disturbed parent-child relationships also are frequent, ranging between 23 per cent and 40 per cent of the total case load among the agencies. All the agencies visited said that a large number of their clients are seriously disturbed people. They range from the psychotic to the mildly disturbed. The great majority suffer a significant degree of psychiatric symptomatology.

Although not all the agencies consider it their function to provide financial and material aid, most of them have a limited budget for purposes of emergency assistance. Often the financial problems of clients are caused by their inability to manage their own affairs well.

Treatment Methods

The major method used by social workers in family service agencies is casework and counselling. This process may involve one person — the client — or more persons — members of the client's family and the therapist. The case worker approaches a case with an orientation to the family as a whole. He obtains the appropriate socio-economic, cultural, psychological and medical data. On the basis

of these data he formulates a diagnosis, and treatment plans and goals. The treatment plan is family-oriented and directed towards helping the client to strengthen his characteristic adaptive patterns and towards mobilizing the strength of all family members in the process. Such supportive techniques as encouragement, reassurance, ventilation of feelings, counselling and education are used. The client is helped to use his capacity to think, to consider, to understand, and hence to re-evaluate himself and his life situation as a means of solving his problems. In working with a client, such direct casework services are often coupled with environmental methods of help, either in stimulating the client to act on his own behalf or, when necessary, in acting for him. This may include any kind of environmental manipulation — for example, change of accommodation or financial assistance. There seems to be a split among social workers on the value of environmental manipulation as a method of treatment. Some social workers see themselves as specialists in marriage and family counselling and try to limit the number of cases which require environmental services. Others believe that such methods of help are perfectly consistent with casework and are, in fact, required and most effective for some clients.

As mentioned earlier, treatment offered by family service agencies is essentially family-centred. "Family psychotherapy" is an important skill and tool of the social worker in these agencies. The functions and responsibilities of the therapist in this kind of treatment are many.¹ Acting as catalyst, he seeks to provoke increasingly candid disclosure of major conflicts and clarifies them by dissolving barriers, defensive disguises, confusions and misunderstandings. By stages, he attempts to bring to the members a clearer and more accurate understanding of their life problems. He counteracts inappropriate denials, displacements and rationalizations, and transforms dormant, concealed intrapersonal conflicts into open, interpersonal expression. He neutralizes processes of prejudicial scapegoating that fortify one part of the family while victimizing another part. He fulfils, in part, the role of a parent figure as a controller of danger, a source of emotional support, and a supplier of elements which the family needs but lacks. His emotional nurturing of the family is a kind of substitutive therapy. He penetrates and undermines resistance, and reduces the intensity of shared conflict, guilt and fear by using both confrontation and interpretation, relying mainly on the former. He serves as a personal instrument of reality testing for the family, and as the educator and personifier of useful models of family health. The duration of contact between client and therapist depends entirely on the individual case. Some clients come in only for the initial interview, while ongoing cases may last from six to eight months to as long as three or four years.

The need for this kind of trained professional service for family problem-solving was made clear in interviews with volunteers in the Big Brother Movement.

¹Nathan Ackerman, "Exploring the Base for Family Therapy", M. Robert Gombert Memorial Conference, New York, Family Service Association of America, 1961.

The purpose of the Big Brother Movement is to provide adult male companionship, support and guidance to boys who, for whatever reason, have no father or viable father substitute. In most cases, the circumstances in which the boy's relationship to his father was severed are associated with familial disturbances which impose considerable emotional stress on the child. Consequently, many of the boys have emotional and behaviour problems. The volunteer "big brothers" find that they are relatively helpless to do anything effective for the boys when these patterns develop. One volunteer reported the case of a boy who practised truancy from school. Each time the boy was truant, the mother would place a call to the boy's "big brother" and beseech him to find the boy and bring him home. But it became clear that the mother actually was subtly encouraging her son's truancy. The limits of the terms of reference of the volunteer's relationship to the boy and his family, and the volunteer's knowledge of family problems and human psychology, made it necessary for the volunteer to resist becoming caught up in the family's pattern of social-maladjustment, while at the same time providing some support and encouragement to the boy in the direction of improved behaviour. The volunteer's view of the situation at the time of the interview was that the boy was headed for juvenile delinquency and that nothing he could do would arrest the process. Field interviews suggested that there is nothing idiosyncratic about this volunteer's experience. The intervention of the trained professional is needed.

Consultation and Referrals

In family service agencies, where the number of professional staff permits the various levels of competence to be well structured, social workers function under systematic supervision and often have direct access to psychiatric consultation. Of the eight agencies questioned concerning the availability of psychiatric consultation, two reported that they employ part-time psychiatrists and one has the services of a psychiatrist for two half-days per month, plus three hours of emergency consultation. Another agency meets once a month with the local mental health clinic, which also accepts direct referrals of severely disturbed persons. The other four do not have regular psychiatric consultation available. They utilize community mental health clinics or general hospital psychiatric facilities. Agencies also make use of the services of private psychiatrists. But judging from the difficulties physicians reported in getting psychiatric consultations for their patients, one cannot be very optimistic about this source. Community clinics also are available in some areas. In the year ending December 31, 1966, family service agencies referred a total of 306 cases to provincial and community mental health services (clinics and hospitals); this amounts to 2.1 per cent of the total number of new cases admitted for psychiatric treatment in such services.²

²See 11th Annual Statistical Summary, Community Mental Health Services in Ontario, 1966. Research and Planning Branch, Ontario Department of Health.

After a client has been referred for psychiatric treatment, the agency follows his progress and does follow-up casework, especially with members of his family. Follow-up of discharged patients is also done on an individual case basis. Many agencies have pointed out that psychiatric treatment is inadequate in the province. They attribute deficiencies not only to the manpower shortage and the want of effective techniques, but also to the strict medical orientation of psychiatrists. Many clients are not able to receive psychiatric treatment at all in provincially operated services, because they do not have the symptoms of a psychosis. The agencies cannot themselves treat these neurotic clients, and they have little success in finding psychiatric help. Agency officials believe that this gap in the mental health field could be met only by a change in the training programs of psychiatrists, so that they receive a more adequate psychodynamic and social orientation.

For psychological consultations and referrals, agencies make use of community resources such as the mental health clinics, the Children's Aid Societies, Ontario Hospitals and school board facilities. Psychological testing and diagnosis are often part of a psychiatric assessment when carried out in mental health clinics. It may be done by school psychologists when the problem is educational in nature. For assessing the physically handicapped, facilities in rehabilitation institutes may be used. Psychological consultation is regarded by family service agencies as of much less urgency than treatment resources. Even so the facilities available are inadequate. Some agencies make referrals to psychologists in private practice. But here the problem of remuneration arises because most prepaid medical schemes (for example, PSI and OMSIP) do not cover psychological services. Many clients cannot afford such services, although some social workers believe that psychological services could be useful to the clients not only for assessment but also for treatment purposes.

There seems to be no problem in the area of medical consultation. One agency has a part-time physician, while all other agencies consult the client's own family doctor, if there is one, in case of need. If the client has no family doctor and if he is covered by an insurance scheme, the agency refers him to a private doctor. If he is not insured, the client is sent to the outpatient or emergency department of a hospital.

Other Community Services

In addition to its casework service, other major functions of a family service agency include group work and community organization. By reason of its knowledge of community resources, family agencies have always been active in improving the social environment through participation in public issues and community organization. One example, is the "After Four Project" sponsored by the Family Service Centre of Ottawa, which is operated in cooperation with twenty other community organizations. The program not only provides late afternoon care of problem school children but also involves the children's families. These families

are often burdened with an oppressive number of economic and personal problems, and have accumulated a host of negative community relations with the school, neighbours, employers or others. The Family Service Centre of Ottawa is especially satisfied with the outcome of this experiment. According to them, it provides "the opportunity for true voluntary participation; the utilization of the resources of the neighbourhood; the opportunity through the children to reach and work effectively with their families; the possibility of linking up families with existing community services and facilitating their effective use of them".³

Operating on a community-wide basis, family service agencies are making a useful mental health contribution at a preventive level. They identify harmful circumstances and seek to counteract them before they produce serious mental disorder. The risk of social and mental maladjustment in the whole population is reduced by fostering in individuals and families the ability to handle major crises in life.

Training

Another function of the agencies which, although not in the form of direct service to the public, is nonetheless of importance to the profession of social work, is the provision of placement settings for the field training of students in social work. Some agencies hope that this will be expanded to include medical students, so that the two disciplines will have a better understanding of each other, an understanding resulting in greater collaboration.

Professional Resources

Many agencies employ only qualified professional social workers (M.S.W.'s). Indeed, family service agencies seem to employ a high percentage of the M.S.W.'s in the province. The seventeen agencies which have supplied information on their staff situation, either through the questionnaire or through interviews, give the totals shown in Table 17.2 (clerical staff not included).

TABLE 17.2

Professional Resources of Seventeen Family Service Agencies in Ontario

Qualification	Full time	Part time
M.S.W.	109	31
B.S.W. or Dip. S.W.	11	7
B.A.	9	3
Other ¹	17	7

¹"Other" includes accountants, home economists, technologists, persons with teacher's training, child care workers and camp leaders.

SOURCE: C. Hanly, J. Wong and M. Landauer, 1967. Data derives from a questionnaire survey of family service agencies.

³The Family Service Centre of Ottawa, Annual Report, 1966.

The distribution of these workers among the seventeen agencies, however, is uneven. There are two agencies who do not have any full-time M.S.W.'s at all and three agencies which have only one full-time M.S.W. On the other hand, there is one agency with thirty full-time M.S.W.'s, and another with twenty-three. (The agency with thirty M.S.W.'s has seven district centres in Toronto.) Agencies located in more remote districts find it difficult to recruit personnel.

By comparing the number of professional staff to the functions of the agencies, one can see that those agencies with more professional staff place greater emphasis on the counselling part of their service, while those with fewer professional staff are more frequently engaged in giving environmental help. The Council for Jewish Organizations in Hamilton for example, has only one part-time M.S.W., who acts as a consultant to other members of staff. This agency is primarily a community centre with a section providing family and individual counselling. But in general the shortage of social workers in the province seems to affect family service agencies least. Directors of agencies explained that the agencies are more attractive to social workers than hospitals and other public institutions, where they have to work under medical direction or under supervisors who have only vague notions about the nature and function of social work, and who therefore tend to regard social workers as nurses or other non-professional paramedical staff. By contrast, family service agencies offer supervision by highly qualified social workers and a working atmosphere which allows the staff full utilization of their training and skills. Agencies appear to respect the principle that a referral to a doctor for examination and medical treatment is mandatory whenever any need for medical attention is suspected. Interprofessional dependency and collaboration is recognized and acted upon by the social work personnel.

Utilization of Subprofessional Resources

As the above staff figures show, subprofessionals are not used extensively by the agencies. These are usually people who have experience in social work but who lack professional training. Except for those who have wide experience and who are responsible for an undifferentiated case load, these subprofessionals are utilized in three directions. They may be engaged in community work, in getting school and clinic reports of clients, in doing follow-up work which makes use of community resources, in paying friendly visits and in providing companionship to clients and members of their family. Agencies have found these workers useful also in providing direct services which do not require the skill of a professional where the client is faced with financial and environmental problems. In the area of personal counselling and relationships, subprofessionals are employed to give supportive counselling to alienated young people, to provide friendly and mature relationships for children who lack them, to act as assistants on cases where the predominant focus of treatment is not in the area of interpersonal relationships.

(for example, in budgeting, financial and multiple-problem cases). A few agencies reported that although they do not make use of subprofessionals at present, their utilization is assumed in their plans for the future.

Coordination of Community Resources

Most of the agencies interviewed feel that coordination among community institutions — for example, among family courts, family service agencies, Children's Aid Societies, Departments of Welfare and Family Services, and school guidance systems — is at present very inadequate. Collaboration occurs at two levels: 1) at the inter-agency level — interlocking of agency services, complementarity of intake practices, interchange of information, establishment of agreements about geographic coverage, continuity of service and financial arrangements, development of joint action on social and legislative issues; and 2) at a case-to-case level in matters relating to an individual client or family, the purpose being to prevent fragmentation and duplication of services. Such integration is important, because each agency is already carrying a maximum work load, and integration helps to ease the pressure of the work. Moreover, in the absence of communication among agencies, much harm can be done to the client whose different needs are being served by different agencies. Treatment plans adopted by different agencies may be opposed to one another. At best client and agencies are likely to be confused about goals and methods of achieving them. It appears that in Ontario social planning and inter-agency collaboration are much better in small communities than in the bigger cities, if only because there is less to coordinate. However, the principle is an important one: human relations are not like industrial production where efficiency of scale is an important factor. On the contrary, the reverse situation may hold in human relations — the smaller the scale, the more efficient and successful the service.

Conclusions

The useful work done by family service agencies in maintaining a mentally healthy community and in providing treatment for the emotionally unstable cannot be doubted. Social workers believe that a large number of their clients would have ended up in mental hospitals had it not been for the family service agencies. The work of these agencies is restricted, however, because of difficulties of organizational coordination and professional collaboration, the latter especially with regard to psychiatric support. Another difficulty which agencies have to face is the limited financial support they receive. One director interviewed ventured the opinion that, at present, the operation of a voluntary agency is too expensive to be supported by private funds. He foresees the phasing out of voluntary agencies. The need is for larger and better government-supported family and children's services, or the extension of Children's Aid Societies to include family counselling divisions. Facilities would then be available to a wider clientele with more thorough treatment services and with stable tax support rather than uncertain private funds. But it

does not seem likely that this change will take place in the very near future. As an interim measure the Family Service Agencies could achieve greater financial stability by contracting with the Department of Welfare and Family Services directly or with the Children's Aid Societies to provide family counselling and casework services.

One point is very clear. If preventive and supportive work in mental health is to be carried out effectively in our communities, some such services, however they may be organized and financed, are essential.

Chapter 18 The Clergy and Mental Health

The various churches and religious groups have become increasingly aware that the nature of the service of clergy to people must adapt to the new mental health resources developed by psychoanalysis and modern psychiatry. In order to accomplish this adaptation, supervised clinical pastoral education is being introduced to supplement the traditional forms of theological education.

History and Background

The clinical training of pastors was initiated forty years ago by Rev. Anton T. Boisen in Worcester, Massachusetts. Prior to taking up his duties as a mental hospital chaplain, Rev. Boisen prepared himself for his new field of service by special clinical studies.¹ Since then clergymen and students for the ministry in the United States have been taking courses in mental health. In Ontario the earliest courses were offered at McMaster University in 1952, through its Department of Extension, to clergy and seminarians to increase their effectiveness in the pastoral ministry. In 1958 the Toronto Institute for Pastoral Training was founded by a committee composed of the heads of theological schools in the University of Toronto (Emmanuel, Knox, Trinity and Wycliffe Colleges); the Professor of Medicine; the Dean of Medicine; the Executive Director of the Toronto General Hospital; and other interested persons affiliated with the University of Toronto. Similar programs, mostly experimental, have been developed in various centres, seeking new methods of clergy involvement in the fields of education and health. These programs include pastors of all major faiths.

Training Programs in Ontario

In Ontario, programs in Supervised Pastoral Education are being offered by the following institutions: McMaster University, Hamilton; the Toronto Institute for Pastoral Training at its three training centres (Toronto General Hospital, Lakeshore Psychiatric Hospital and Ontario Department of Reform Institutions, Brampton); Queen's University, Kingston; and the Ontario Hospital, London.

With the cooperation of the hospitals in the Hamilton Health Association, the Hamilton Civic Hospitals and the Ontario Hospital, Hamilton, McMaster University operates four different types of programs for clergymen.² The courses

¹Chaplain Charles Scott, "The Aims and Methods of Clinical Pastoral Theology", introductory lecture to chaplain internes by Resident Chaplain, SPE Programme, Ontario

²The Ontario-Quebec Region of the Association of Mental Health Chaplains, Brief to the Committee on the Healing Arts, December 1966.

include lectures from medical doctors on understanding human behaviour, lectures from social workers to help the students become aware of the various community resources available to people in need of help, lectures from theologians to help the students integrate their religious beliefs with their scientific insights and knowledge. In addition to these lectures, the students are required to visit patients in hospitals and to write reports on the visits. These reports are evaluated by a trained supervisor and are subsequently criticized in seminars by their peers.

During the years that this program has been in operation it has had students with the following religious affiliations: Anglican, Christian Reformed, Christian and Missionary Alliance, Baptist, Evangelical, United Brethren, Lutheran, Menonite, Presbyterian, Quaker and United Church of Canada. As of August 31, 1966, a total of 394 students had taken part in these courses.

The Toronto Institute for Pastoral Training is an independent Ontario institution. It offers courses involving the following:

- 1) Pastoral interviews with patients in the institutions, followed by verbatim written reports by students.
- 2) Personal sessions of students with the supervisor.
- 3) Daily sessions (one and one-half hours) in group dynamics and small group communication.
- 4) Verbatim report seminars in which the students' work with patients is examined with the supervisor and a group of peers.
- 5) Theory seminars on the implications of the social and biological sciences for pastoral care and counselling.
- 6) Field trips to other treatment institutions (the Alcohol and Drug Addiction Research Foundation, the Juvenile and Family Court, etc).

These courses are available, entirely or in part, to clergy and theology students for different periods.

This work is offered by the TIPT through the Division of University Extension, University of Toronto. One hundred and thirty-eight students have completed these courses during the period from 1962-1966. Most of these students are parish clergy and religious workers, theological students and institutional chaplains; but also among the graduates are two theological professors, a family counsellor from the Juvenile Court, a missionary and a university worker. Their religious affiliation includes Anglican, Baptist, Lutheran, Presbyterian, Roman Catholic, United Church, and non-denominational.

These educational programs are reasonably typical of the work being done. A different kind of course has been established by the Program Director of the Pastoral Theology Program in London, who is also resident chaplain of the Ontario Hospital, London. He has formulated a three-year program to prepare clergy for marriage and family counselling; he is seeking funds (\$150,000 for the

three-year period) to cover the costs of the program.³ The program offers full-time intensive training and grounding in dynamic psychology, the theory of counselling and psychotherapy, plus one year of supervised experience. During this period the chaplain interne will be placed in direct contact with patients.

Competence and Jurisdiction

Some concern has been shown by the medical profession that the minister, having received some training in psychiatry and the behavioural sciences, may think himself competent to handle cases of mental disturbance. In response to this concern, the Canadian Council of Supervised Pastoral Education has explained⁴ that although such a danger may exist, one of the purposes of these courses is to enable the pastor to recognize his limitations. The courses do not train a man to be a therapist; on the contrary, they make him more aware of the problems he is going to meet with people who are in hospitals, in penal institutions, in homes for the mentally retarded, or in his own parish. Thus he is alerted to serious health problems and is able to judge when a physician or psychiatrist should be consulted. At the same time, the clergyman so trained is better able to engage in effective counselling. These considerations apply to existing educational programs. But the training program designed to prepare clergy for marriage and family counselling clearly overlaps with psychiatry and psychology. Clergy so trained would be trained to perform the same tasks handled by psychiatrists and psychologists. Without questioning the need for such therapists or questioning the principle that non-medical professions can be trained to do psychodiagnosis and psychotherapy, one can question the wisdom of training in psychodiagnosis and psychotherapy under church auspices. It would be better to have independent schools, where clergy wanting advanced training in mental health could obtain it.

Standards and Accreditation

Formal training for pastors in the clinical field is such a new development that until recently standards and accreditation facilities have not been available in Canada. But in December 1965 the Canadian Council for Supervised Pastoral Education was formed for the purpose. The Council, a national organization, is a regulatory body which accredits programs and certifies supervisors of courses in Supervised Pastoral Education, provided that they meet set standards. These standards are still in the process of implementation. As a result, programs in Ontario have been seeking guidance and accreditation from agencies in the United States. The Council for Clinical Training in New York and the Institute of Pastoral Care, Boston, for example, provide supervisory facilities and have minimal standards and curricula for clinical training programs. They accredit

³The London Institute of SPE, Draft Proposal of a Course in Marriage and Family Counselling, the Ontario Hospital, London.

⁴Proceedings of the Committee on the Healing Arts, May 23, 1967, pp. 2981-3004.

supervisors of such programs. Standards are set also by the American Association of Theological Schools. The Baptist Church and the Lutheran Church have their own certifying agencies in the United States.

The standards set down by the Canadian Council for Supervised Pastoral Education for the accreditation of training programs include setting of the program, structure of the program, and content of courses.⁵ In general these standards ensure the availability of teaching staff, physical facilities and financial support. They also require that each program be supervised by at least one person certified as a qualified supervisor and engaged in an established and recognized ministry. Minimum requirements are set also as to the duration of each course; the relationship between student and supervisor; the provision of conferences and seminars; the study of personal and social dynamics; the understanding of the relationship between theology and other disciplines, such as medicine, psychology, sociology, anthropology; and the study of research methods for advanced courses.

In the Procedure for the Certification of Supervisors, it is stated that a person must have completed

- 1) not less than six months in an accredited program; after this he proceeds to
- 2) a further six months of probation training;
- 3) to be certified as Acting Supervisor, he then completes three months' training as assistant supervisor.

Certification as Acting Supervisor is subject to annual review by delegates of the Accreditation and Certification Committee of the Council. After three months' training as an Acting Supervisor, he is eligible for certification as a Supervisor of a clinical pastoral training program. Certain other requirements, which are prerequisite to admission into the probationary training course, must also be observed. The student must

- 1) have graduated from a recognized college or university and from a recognized theological school;
- 2) have been ordained or certified in a pastoral vocation or ministry;
- 3) hold membership in the Canadian Council for Supervised Pastoral Education;
- 4) supply evidence of satisfactory pastoral experience and certain personal qualities appropriate for such training.

It should be noted that these standards are applicable only to those ministers serving as supervisors of theological training programs. They do not apply to chaplains in public institutions, except when they act as supervisors of such programs as well. The Council, however, hopes that its standards will also be

⁵The Canadian Council of SPE, Brief to the Committee on the Healing Arts, January 1967. Appendix.

used by agencies desiring to appoint qualified chaplains to public or private institutions, and that these standards will meet the requirements of the Canadian Council of Churches Committee on the Certification of Chaplains in Public Institutions.

The Canadian Council of Churches is the accreditation body for hospital chaplains.⁶ The required qualifications of a chaplain are as follows:

- 1) He shall be a graduate of an accredited college and theological seminary, fully ordained and with good standing in a recognized faith group.
- 2) He shall have completed a period of clinical pastoral training of at least one year's duration, at least six months of which shall have been in a mental hospital; alternatively, he shall have had some period of clinical pastoral training and shall have served in a voluntary capacity as a mental hospital chaplain for not less than one year.
- 3) He shall have indicated willingness and desire to seek further specialized training.
- 4) He shall have the endorsement of the Canadian Council of Churches' Department of Social Relations, through its Accrediting Committee for chaplains in Mental Hospitals.

Apart from accreditation at a professional level, students of clinical pastoral training programs also seek accreditation at the academic level. In general, the training institution (which could be a hospital or an educational organization like the TIPT) does not give academic credit or confer degrees on students of pastoral programs. However, as such programs usually are organized in conjunction with universities, before taking the courses the student could arrange for recognition of them as a credit towards his degree in theology at his college.

Functions of Clinically Trained Pastors

Although it is recognized that clinical pastoral education is necessary for all theological students who are going into the public ministry in a parish setting, very few ministers have as yet undergone this training in Ontario. This is explained primarily by the short history of the program here and the small number of established programs now in existence. A large number of those who have had this training are retained to offer their services in specialized settings, to act as chaplains in public institutions or as supervisors of clinical pastoral education programs, or as both. Where chaplains work in public institutions in Ontario, such as the Ontario Hospitals, penal institutions, Addiction Research Foundation Centres, and homes for the mentally retarded, they become paid

⁶The Ontario-Quebec Region of the Association of Mental Health Chaplains, Brief to the Committee on the Healing Arts, December 1966, Appendix.

employees of the provincial government. It is not known how many ministers there are who have taken the clinical training course and are working in specialized settings, but the majority (about sixteen) are working as mental health chaplains in the Ontario Hospitals.

The primary function of the chaplain is to provide a spiritual ministry to patients in the hospital, which includes the provision of scheduled services of worship for all those who can and wish to attend such worship services, and a pastoral ministry to patients. In addition, he is expected to interpret the function of the chaplain in the hospital and the meaning of religion to other hospital personnel; to interpret to the community (church and civic groups) the work of the hospital and the relationship of religion to the problems of mental health; to encourage, where possible, programs for the clinical pastoral training of seminarians and clergy, and to offer opportunities for clergy to obtain specialized training in the ministry to mentally ill persons; and to utilize whatever community resources are available for the extension of this ministry.

The hospital chaplain is often invited into psychiatric settings as a member of a therapeutic team in individual, family and group counselling, especially when patients and their families have strong religious commitments. The pastor will also pay regular visits to hospital wards. His task is to take an interest in the welfare of the patients, to offer friendship, and to help them verbalize their problems. He will interview patients referred to him by medical doctors when these patients have problems of religious guilt and fear. In this work of pastoral care, ministers have been visiting hospitals and giving encouragement to patients for generations. The difference is that only now are the clergymen beginning to incorporate the knowledge of the social sciences and biological sciences in human growth and behaviour, and to utilize their insights and methods in the functions of the ministry.

Teaching is also one of the main functions of the hospital chaplain. Depending on the qualifications of each individual chaplain, he may be the supervisor of chaplain internes in a clinical pastoral program, or he may be on the teaching staff for social workers and nurses. He frequently discusses particular cases with other pastors who have been called in by the patients concerned and who have had no clinical training.

The pastoral function in a hospital is not limited to the patients alone. It includes assisting staff at all levels, and visiting clergy and relatives of patients. The chaplain introduces local clergy to the hospital and organizes lectures and seminars for them by psychiatrists, social workers and others. He serves a public relations function on behalf of the hospital, helping to bridge the gap that has existed for so long between the mental hospital and the community, and to reduce

the stigma attached to mental illness. All chaplains and training institutions for pastoral education are active in the work of involving the lay community in the work of the hospital, to promote understanding of mental illness and of the care and treatment of the mentally ill.

The Toronto Institute of Human Relations

As we have seen, the services provided by the clergy with clinical pastoral training are involved directly in the mental well-being either of patients in specialized settings or of parishioners in a public ministry. However, these services are supportive of and complementary to, rather than competitive with, services provided by psychiatry and psychology. The psychiatric patient sees the pastor as a sympathetic and helpful friend, rather than as a therapist. There is a different group of clergy to whom the term "pastoral counsellor" applies in a very different sense. This group is known as the Toronto Institute of Human Relations. It was organized by its two Executive Co-Directors, the Rev. Kenneth R. Allen and the Rev. J. Meroya Dickenson, who are "specialists in pastoral counselling" and who serve as consultants and colleagues to the "general practitioner" — to the pastor who has not had this specialized training in pastoral counselling.

The Institute is a non-profit, church-related organization, established in early 1967 through a merger of the Pastoral Counselling Service and the Toronto Institute of Family Relations. The PCS was established in July 1963 and the TIFR in October 1964. Both provided a service of personal, marriage and family counselling to anyone requesting it, regardless of religious affiliation or referral source. The Toronto Institute of Human Relations is governed by a Board of Directors composed of representatives of the sponsoring congregations and the two Co-Directors. All services offered are free of charge. The institute is financed almost entirely through the support of local congregations. A small portion of the budget is raised through voluntary contributions.

The two Executive Co-Directors, Drs. Allen and Dickenson, are ordained ministers of the United Church of Canada, with extensive training and experience in human relations counselling and education. Both are graduates of Victoria and Emmanuel Colleges in Toronto and hold Ph.D. degrees in Psychology and Pastoral Counselling from Boston University. They are also certified as Acting Supervisors of Pastoral Education Programs by the Canadian Council for Supervised Pastoral Education. Prior to the establishment of the Institute, Dr. Allen served as Director of the Toronto Institute of Family Relations and Dr. Dickenson as Director of the Pastoral Counselling Service.

The Institute seeks to assist Toronto-area churches in their own ministries by

- 1) Offering a service of individual and family counselling to persons seeking help, with priority given to those referred by Toronto-area churches.

- 2) Providing opportunities for professional education and consultation to clergy and others in the field of pastoral counselling and human relations.
- 3) Developing leadership and program resources for community education, especially in the area of marriage and family life.
- 4) Initiating and encouraging research in human relations with particular reference to the life and ministry of the Christian community.

The direct counselling service to individual and families involves about one-half of each Co-Director's time. Persons suffering from psychosis or very severe character and behaviour disorders are not accepted for counselling. The counsellors at the Institute deal with people who have less precisely medical problems, and they try to sustain long-term relationships with the clients. After an initial interview with the pastoral counsellor, the client who wants to continue the treatment is given appointments for further sessions. Each session lasts fifty minutes, and the average client comes for about five sessions. Those who are engaged in long-term therapy come for about fifteen sessions, while some may have as many as fifty sessions spread over a period of twelve months. Persons who are severely ill, or who require longer treatments or the application of drugs, are not treated by the pastoral counsellors; instead they are referred to a psychiatrist. The Co-Directors meet each week with a consulting psychiatrist for a ninety-minute case conference dealing with current counselling cases. Each Co-Director spends about twenty-one hours per week in this counselling program.

The Institute provides consultative services for clergy of the community in such matters as follow-up on current referrals to the Institute, case conferences with the Institute staff and its consulting psychiatrist, assistance to parish clergy in dealing with difficult counselling cases which they themselves are carrying, and other problems in pastoral care.

A wide range of educational programs is offered each year for clergy and interested laity. These include workshops, seminar series, two-week institutes, sensitivity-training groups and counselling internships. There are at present four internes under supervision in the Institute. The course content is flexible and varies according to practical need. The internes spend one and one-half hours per week with a psychiatrist and social workers, and one and one-half hours per week with the supervisors, Drs. Allen and Dickenson. These internes are all ordained clergymen with pastoral experience and training in counselling (for example, an M.A. in psychology or courses in clinical pastoral training). Candidates are selected also on the basis of the suitability of their personality to counselling work.

Consultative help for community education in leadership and program development is available to those churches seeking help in initiating programs such as family-life education, parent-teen workshops, marriage preparation

courses, sex education programs, and communication-in-marriage groups. Refresher courses and supervision are also provided to lay persons who have had previous training in counselling and who wish to contribute a few hours of counselling time per week to their local church.

Conclusions

One must draw a clear distinction between informed pastoral support work by clergymen based on a clinical training program of the type offered at McMaster and the Toronto Institute for Pastoral Training, on the one hand, and the performance of psychodiagnosis and psychotherapy on the other. The latter are specialized professional services requiring specialized training in psychoanalysis, psychiatry or clinical psychology.

In keeping with this distinction one must differentiate between the work of the chaplain or parish clergyman trained in pastoral counselling, which does not overlap at any point with that of psychiatrists and psychologists, and the work of the directors of the Toronto Institute of Human Relations, which clearly does. Since these pastoral therapists perform services that are in no way different from services that might be performed by a clinical psychologist, their training, registration and other qualifications should be the same. Theological training is not relevant to the nature of the service but only to the context in which it is offered.

The import of this distinction is not to criticize the work of the Toronto Institute of Human Relations, or to commend it, but only to indicate a significant difference in the nature of the services and to suggest that any relevant legislation should take it fully into account. Otherwise, the procedures for accrediting and recognizing pastoral counsellors that are in formation would appear to be quite adequate.

The interest among some pastoral counsellors in developing a full-fledged professional capacity for psychodiagnosis and psychotherapy is yet another piece of significant evidence in favour of the establishment of a training program for non-medical psychotherapists along the lines suggested by Kubie.

Part Four: Prospects for Mental Health in Ontario

Chapter 19 General Conclusions

An Economic Consideration

There is a basic economic issue involved in this report. Can a larger expenditure of public funds for the improvement of mental health services be justified on economic grounds, given the current state of psychiatric, psychological and social science and the methods they make available for treating mental disorders of all kinds? No scientific answer to this question is available. The one major study that exists applies to the U.S.;¹ but even it is devoted largely to an analysis of the problems involved in getting the scientific data necessary to generate a reliable result. It provides an answer to our question in only one respect.

It is easy to suppose that the cost of bringing about improvements in the mental health of a population is an incremental cost; one that must be added to the cost of other social services and deducted from the wealth generated by productivity. This concept is fallacious. Part One (pp. 20-24) of this report provides some details on the prevalence of mental illness in Ontario's population. Impaired mental functioning involves a whole range of costs: work inefficiency, actual loss of work hours, a host of social costs such as alcoholism, delinquency, the support of children from broken homes, and so on — not to mention the individual costs of these and other expensive mishaps, such as traffic accidents directly traceable to disordered mental functioning.²

Therefore, society does not have before it the question: Will it or will it not sustain the costs of psychopathology? Rather it has only the question: In what ways will the cost be sustained? Fein's preliminary study supports the conclusion that it is *probable* that major investments in the improvement of mental health services will prove to be the least expensive way of meeting these costs. Real improvements in the mental health of a population will more than meet the costs involved in bringing it about, because improved mental health leads to improved productivity and the reduction of other social costs. This argument will become

¹Rashi Fein, *Economics of Mental Illness*, Joint Commission on Mental Illness and Health, Monograph Series No. 2, Basic Books, New York, 1958.

²W. Tillman, M.D., a psychiatrist practising in London, Ontario, has demonstrated the connection between neuroticism and automobile accidents.

more convincing with time as science and technology advance, as more people are educated to a post-secondary level, and as the need increases for the services of highly trained people in all areas of society who can function at a high level of efficiency.

Certain other less tangible benefits also must be considered. Social science has established the link between neuroticism and various forms of hostility (racial prejudice, political extremism and militant nationalism).³ If we are to ever bring a sane, just and humane society into being, then we must, as a society, take all the intelligent, realistic steps available to help individuals correct the forces in themselves that produce destructiveness, injustice and ignorance.

What Mental Disorders Should Be Treated, and How?

A second problem arises immediately. Given the limited professional resources available, would it not make more sense to concentrate these resources upon the treatment of the most severe forms of mental illness — those that usually require hospitalization (psychoses, and severe character disorders), leaving neurotic persons to make the best unassisted adjustment to life that they can? This problem is compounded by a second closely related one. The major form of treatment for neurotic disorders is psychotherapy. But psychotherapy is criticized as being demonstrably useless for the treatment of severe mental illness. "Individual psychotherapy has failed as a major social strategy for the containment of disabling mental illness. It has failed with the character disorders, with the addictions and with the criminal psychopath."⁴ This argument has been extended to the treatment of the neurotic disorders and has been used as an argument against the training of more psychotherapists.

We have, in essence, a proposal that we should train large numbers of people to treat the least pressing of society's mental ills — neurotic problems — by emphasizing a general technique — psychotherapy — that has yet to demonstrate its value, in this or any kind of psychological deviation.⁵

This statement by B. A. Maher combines the two-fold doubt of some psychiatrists and psychologists expressed in the questions: What benefits derive from treating psychoneurosis in patients at all? What benefits derive from treating it by means of psychotherapy?

No one would deny that there are no scientific validations, using control groups, of the efficacy of psychotherapy or psychoanalysis. As the President of

³See W. Eckhardt and N. Z. Alcock, "Ideology and Personality in War/Peace Attitudes", and N. Z. Alcock and W. Eckhardt, "Towards a Theory of Social Behaviour". Papers presented at the Annual Meeting of the Canadian Peace Research and Educational Association, Calgary, June 1968.

⁴C. G. Pennett, "Manpower and Psychiatry: university perspectives", in *Manpower and Psychology*, No. 1, 1963.

⁵Brendan A. Maher, "Training for Professional Psychology", *Canadian Psychologist*, Vol. 6, No. 1, p. 135.

the American Psychoanalytic Association pointed out, the reason for this situation is not hard to find. It would be contrary to any decent morality to use neurotic patients as guinea pigs for controlled studies of the efficacy of psychoanalysis.⁶ The same would apply to psychotherapy. The fact is that psychotherapy has been proved neither efficacious nor inefficacious in the narrow scientific sense. However, it has proven to be efficacious enough, to enough persons, to justify fully its continued and expanded use. For example, a psychiatrist has a consultation with a patient who is suicidal; he then treats him by means of psychotherapy over a period of months, during which time he helps the patient become aware of and resolve the forces at work in his life producing the suicidal tendency. The patient leaves therapy with a new understanding of himself and an improved functioning which makes him proof against his former suicidal tendencies. This type of experience provides the psychiatrist with all the evidence he requires to proceed with his therapeutic work. The data concerning the prevalence of the use of this treatment method as compared with other methods by Ontario's psychiatrists are satisfactory indirect evidence that this experience is not limited to a few eccentric practitioners (Tables 3.2, 4.8).

Part of the difficulty the critics of psychotherapy have in making an evaluation derives from their own paradigm of successful treatment. This concept can be defined roughly as the removal of pathological symptoms by means of a repeatable mechanical process which eliminates the cause of the symptoms. The injection of a drug which produces an involuntary chemical effect in the body and removes a set of symptoms is an example of such a curative process. But psychotherapy is a psychological process which is in part voluntary. Thus it requires the full cooperation of the patient. It is also in part involuntary, in that the patient responds unconsciously to the therapist's interpretations and confrontations. But the result is not so much a cure in the sense of the removal of some disease entity as a redistribution of instinctual energies and an improved self-understanding which makes the individual more able to live successfully, meaningfully and without psychological symptoms.

It is not clear that any less time-consuming method for treating neurotic disorders will ever be invented. Even with the discovery of mind-changing drugs of a quality far superior to those that now are available, there will always remain the problem of integrating the changes automatically and mechanically produced by drugs into a stable, reality-oriented, healthy personality. In any case, no such mind changing drugs or other mechanical techniques are now available, or are likely to be soon available for the treatment of neuroses. Consequently, the burden of treating neuroses must fall on the shoulders of psychotherapists and psychoanalysts. Many more psychotherapists and psychoanalysts are needed, if resources for treating psychoneurotic illness are to be increased.

⁶Field interview with Charles Brenner, M.D., President, American Psychoanalytic Association, New York, October 1967.

The first part of the question must then be dealt with: Is there a case for investing substantial resources in developing many more psychotherapists so as to treat more psychoneurotic disorders? The basic answer to this question is quite simple. Although psychoneurotic disorders are usually not as severe as psychotic illnesses, they are still serious forms of mental ill health which require treatment by competent professionally trained people. A woman suffering from severe agoraphobia is not only in a condition of personal psychological distress and handicap; she is also unable to carry out the essential functions of her life. If she is a wife and mother, her illness will pose a threat to her marriage and to the healthy maturation of her children. This condition responds to psychotherapy. It would be as absurd to plan a mental health service in which there was no provision for the treatment of illnesses of this type as it would be to plan an orthopaedic service in which the less severe bone fractures would not be treated, on the grounds that they would probably not kill the patients, if left untreated, and would likely reknit without any special medical intervention, even if the foot might become crooked and never again function properly or adequately.

In terms of its frequency, psychoneurosis is much more important than psychosis. Psychosis is a relatively uncommon condition representing considerably less than 16 per cent of significantly disabling mental illnesses, whereas psychoneurosis represents approximately 84 per cent of such illnesses (Tables 4.5, 4.6, 4.7). The percentage of psychotic illnesses will decrease as one expands the criteria for mental illnesses to include the less disabling disorders. This fact is reflected in the experience of the province's general practitioners as reported in an earlier section (Table 5.5). Therefore, it would be irresponsible not to plan health resources which include the best possible services for the treatment of at least the more severe psychoneurotic disorders.

To this argument there should also be added the consideration adduced in the introductory section of this report. If Ontario's mental health services were permitted to stagnate at their present level of development and become limited almost entirely to the treatment of hospitalized patients, it is likely that the quality of these services would decline, because talented young people would not be attracted into professions exclusively devoted to them. In order to attract the most talented, more opportunities are needed for a diversified professional practice and a hospital system that provides diversified practice experience in terms of inpatient, outpatient, hospital and private practice, research and teaching, as well as opportunities to treat both psychotic and neurotic patients.

The most basic consideration is a simple one. Persons suffering from psychoneurotic disorders are just as deserving of the best treatment available as persons suffering from psychoses. Consequently, the province requires more psychotherapists who are trained to treat psychoneurosis. These therapists also could contribute to the treatment of at least some psychoses which have been brought under control by drugs, when there is a need and capacity for more insight by the patient into

the psychodynamics of his condition. Such therapists could become involved in the treatment of alcoholics, especially that group of alcoholics who have been able to remain employed and are able to recognize the threat of the alcoholism to themselves and their dependents. Psychotherapists could treat adolescent delinquents, emotionally disturbed children, university students and other young people encountering difficulties in maturation. They could assist physicians in the treatment of psychosomatic conditions in their patients. In short the need for more psychotherapists is one of the most critical needs in mental health in the province.

The Need for Psychotherapists

This need has been studied and documented by many writers, but by none more effectively or constructively than L. S. Kubie, an American psychiatrist and psychoanalyst.

. . . the obstetrician in the delivery rooms, the educators in the nursery and kindergarten, in grade and high school, in colleges and graduate and professional stratospheres of education, all are seeking whatever light the psychiatrist can throw on their problems. Competing for his services are children's courts, domestic relations courts, criminal courts, reformatories and prisons, probation officers, and every other organized effort at rehabilitation. In industry his help is sought in personnel work, in the allocation of men to proper tasks, in grading loads to man's capacity, in sheltered workshops. He is sought by every variety of social agency and by churches to deal with the human problems of parishioners. Sometimes his aid is sought even on larger issues of national and international import. At the same time, and to an ever-increasing extent, he is invited to share in the healing work of the medical and surgical wards of adult and pediatric services, of all the specialist services in general hospitals, and in every out-patient clinic, and especially in the institutions that are growing up to care for the long lived sufferers from chronic illnesses and from the disabling residual impairments of past disease whose acute phase the patient has survived. Please note that this astronomical list has not yet included the psychiatric hospital, the psychiatric out-patient department, or the consulting room of the private practitioner. Nor has it included the many administrative and policy functions which the psychiatrist is called upon to fill in medical schools, where he must first help to screen the applicants, and then all too frequently he is called upon to treat as well as teach his medical students, and many of his colleagues as well.⁷

Dr. Kubie is describing the situation in the areas of the U.S. where psychiatry and psychiatric services are better developed than anywhere in the world. The implication for Ontario is very clear. We now have serious shortages of psychiatrists, psychologists, social workers, psychiatric nurses and occupational therapists. These shortages will become more critical as the pressures for more and better services grow.

⁷L. S. Kubie, *op cit.*, pp. 283-284.

Dr. Kubie has postulated a factor arising out of the growth of medical science and technology that will also add to this pressure.

Large additions to this demand arise as a consequence of the fact that all of medicine is passing through a long period of half-cures. Every medical and surgical discipline must go through stages in which it can keep people from dying or from becoming totally disabled, but without restoring them to full health. This is happening today in every aspect of organic medicine and surgery, and in psychiatry itself. We are being challenged on all sides by increasing numbers of human beings who are half-sick and half-well, and who, because of the triumphs of modern medicine, reach old age in that state. The problems which this creates are self-evident; and these patients and their families are being brought to psychiatrists in increasing numbers for psychodiagnosis and psychotherapy.⁸

According to the comments received in the open section of the questionnaire to physicians (Study 3), this pressure is already being felt by Ontario's medical practitioners.

There are other factors that might be added, such as the increasing concern about prevention, the excellent educational work of the National Association for Mental Health, the World Health Organization and the World Federation of Mental Health. The combined effect of all these factors is an explicit and implicit demand for psychodiagnostic and psychotherapeutic services that far outstrips the numbers of psychiatrists able to provide it. Kubie goes on to point out a major implication of this situation.

... there are not enough trained psychiatrists to meet even a minute fraction of this demand. Instead, (one) find(s) here and there *one* psychiatrist of varied training giving, at the worst, a demonstration of how *not* to do such work. At the best, he supplies a small sample of how valuable such services might be if only enough trained personnel were on hand. Thereby he creates an impatient demand for more. But since there are no psychiatrists to satisfy the hunger which he has roused, the frustrated claimant turns in anger to the untrained, to the cultist, and to the quack, who will exploit his need.⁹

It follows from these arguments that the most effective way, and in the end the only way, of coping with the danger of quackery in mental health is to train the numbers of qualified persons needed to serve the mental health needs of the province's population. It would make more sense to spend money on this approach than to invest large sums in administering legislation designed to prevent quackery by punishment. This argument is not an argument *against* such legislation. It does, however, establish the limits of its usefulness.

Current Resources

Early sections of this report have documented Ontario's need for increased thera-

⁸*Ibid.*, p. 284.

⁹*Ibid.*, p. 285.

peutic resources in mental health. A major impact of this shortage, resulting in grossly inefficient use of some of the resources that are now available and profound frustration for all concerned, can now be analyzed and described. The treatment process always consists of three stages: identification, diagnosis and treatment. We now have more resources for identification and diagnosis than we have for treatment. The result is bottlenecks in every service; at best, at the second stage — diagnosis — at worst, at the first stage — identification. Doctors, and general practitioners in particular, report many cases of neurotic disorders, often associated with somatic symptoms, which they are able to identify as such and diagnose in a preliminary way but which they are not able to treat to their — or presumably, to the patient's — satisfaction. The Department of Reform Institutions has reasonably well-developed diagnostic services for the inmates of the reform institutions, but relatively little is available for treating those inmates who, while not psychotic, are in need of therapy and have some prospect of benefiting from it. The schools of Ontario each year identify many students in need of psychotherapeutic help, if they are to make a success of their educational experience let alone their personal development, but there are no treatment resources available for them. The same problem is encountered by family service agencies and by the Alcoholic and Drug Addiction Research Foundation, and by Children's Aid Societies. Diagnosis without treatment is utterly futile. And the fact is that diagnosis preparatory for, and as part of, treatment requires a special set of trained observational and cognitive skills which the educational psychologist, the psychometician, the social worker and the teacher cannot be expected to have. Only when the problem is seen in these proportions can its real magnitude be appreciated. It can be seriously attacked and significantly reduced only by training many more psychotherapists. It is the shortage of skilled, expert psychotherapists that is by far the greatest single factor causing inadequacy and lack of merit in the province's mental health services.

Methods for Providing More Psychotherapists

Thus the central problem facing mental health in Ontario is how to train the numbers of skilled psychotherapists required. It is clear from the details of this report that there are a number of different options. These are:

- 1) To limit psychodiagnosis and psychotherapy to qualified psychiatrists and to undertake to train sufficient numbers of psychiatric psychotherapists who would form a specialty within psychiatry (Chapter 4).
- 2) To extend psychodiagnosis and psychotherapy to medical practitioners and to undertake to improve the psychiatric content of undergraduate training sufficiently to make general practitioners competent in this area (Chapter 5).
- 3) To extend psychodiagnosis and psychotherapy as in 2) but also to include psychologists, psychiatric social workers and psychiatric nurses with advanced (doctorate) training (Chapters 7, 9, 10).

- 4) To train a new clinical profession of psychotherapists that would be prepared specifically to perform psychodiagnosis and psychotherapy (Chapter 11).
- 5) To train subprofessional personnel to perform mental health counselling under supervision (Chapters 8, 12).

This report has already provided reasons for rejecting the first and second options (Chapters 4, 5) and for adopting the third with a number of conditions being understood. These are as follows:

- 1) Before a physician, psychologist or social worker is allowed to practice psychodiagnosis and psychotherapy, each must be properly prepared by a training program that provides as much theoretical and supervised practical work in psychodynamics as is now required of psychiatrists who train to be psychotherapists. In particular, experience with control cases under supervision is necessary.
- 2) A non-medical psychotherapist should be obliged to diagnose and treat patients only on referral from a doctor who is responsible for medical diagnosis and medical treatment prior to and during treatment by a psychotherapist. The psychotherapist is responsible for the psychodiagnosis and psychotherapy.

A failure to meet the first condition would result in the weakening of the standards of psychotherapeutic practice. A failure to meet the second would result in risks to the health of individuals through the failure to diagnose and treat an associated organic illness.

In the light of these preconditions, it also becomes apparent that a general practitioner could not be adequately prepared by his undergraduate medical training to practise psychotherapy but would need postgraduate training, as does the psychology, sociology or humanities major. This consideration, in itself, provides an important argument in favour of the fourth option, if that option is understood along the lines of proposals made by Kubie, whose views concerning the need for such a profession have already been presented (Chapter 11). Given the difficulties inherent in training general practitioners for this work, it is not realistic to look to them for the required services. And, given that a new type of training program is needed for a new profession, the same training program could be used to prepare such general practitioners as have a special interest in and aptitude for psychotherapy.

The two preconditions stated do not rule out vigorous steps along the lines of the third option. On the contrary they support it. However, it is essential that training in psychotherapy for psychologists and social workers should be at least as good as the training available to psychiatrists who have specialized in psychotherapy. At the present time this standard could not be achieved without the full support of psychiatrists, if any expansion of the numbers of clinical psychologists

in training were to occur, because of the shortage of psychologists who are top flight psychotherapists. This shortage is a reason for attracting such psychologists from the U.S., because psychiatric teachers will be kept busy expanding training programs in psychiatry. It does not provide an argument for denying to psychologists opportunities for such training.

Unfortunately a major effort to provide the needed psychotherapists cannot be expected from Ontario psychology. A realistic view of psychology and how much it can offer to the development of psychotherapeutic services in Ontario during the next two decades must take into account at least three considerations:

- 1) Some of the largest psychology departments in Ontario's universities — Toronto, Western, McMaster and Carleton — are devoted almost entirely to experimental psychology. In the university departments that have clinical sections, such as Queen's, York, Waterloo and Ottawa, the clinical members are, in most cases, a relatively small section of the department, the clinical program is relatively new, and its financing is often somewhat precarious.

Clinical psychology is the weakest and least developed branch of psychology in university departments. It is often viewed with suspicion and resistance by those who dominate the departments — the experimentalists.

- 2) The second precondition (above) makes it mandatory that there be close professional cooperation between medicine and psychology. Without faulting either profession, there is little evidence of a willingness on the part of medicine to train physicians to work closely and effectively with psychologists in the treatment of psychoneurotic patients. There is also little evidence that this cooperation occurs spontaneously as frequently as it would have to if a great many more psychologists were to become usefully involved in psychotherapy.
- 3) Many psychologists, especially in Ontario, are preoccupied with differentiating clinical psychology theoretically, diagnostically and therapeutically from psychiatry, and to the same extent they are not interested in training themselves or others to become psychotherapists.

For these reasons it is unrealistic to assume that the public need for psychotherapeutic services can be met by simply allowing psychologists who meet the two preconditions specified above to practice it. Approximately the same considerations apply to social work, as the section devoted to psychiatric social work indicates. Consequently, the fourth option must be given the most serious and urgent consideration.

The details of the Kubie proposal to establish a new profession of non-medical psychotherapists have already been outlined (Chapter 11). No other single step

would contribute more to the growth of the kind of professional resources that are so badly needed in every aspect of mental health in the province: hospitals, community clinics, private practice, residential treatment centres, specialized clinics and family services. One of the most attractive features of the proposal is the strong working relationship that could be established between such a profession and medicine. It is therefore urgent that the establishment of an institute for the training of such professionals at an appropriate university should be adopted as a first priority. Such a development would not detract from or substitute for the efforts being made at York, Waterloo and Queen's to strengthen postgraduate education in clinical psychology. On the contrary, it would strengthen and support their work. This is a field in which there is not the slightest danger of the unnecessary duplication of effort in the foreseeable future.

Freud has emphasized in a slightly different context an extremely important secondary advantage to be reaped by the establishment of such an educational and training institute in a university.

In the investigation of mental processes and intellectual functions, psycho-analysis pursues a specific method of its own. The application of this method is by no means confined to the field of psychological disorders, but extends also to the solution of problems in art, philosophy and religion . . . thus the general psycho-analytic course should be thrown open to the students of these branches of learning as well. The fertilizing effects of psycho-analytic thought in these other disciplines would certainly contribute greatly toward forging a closer link, in the sense of a *universitas literarum*, between medical science and the branches of learning which lie within the sphere of philosophy and the arts.¹⁰

No university in Ontario yet enjoys these advantages.

Certification and Licensing

It is expedient in this context to consider the general question of certification and licensing procedures in the mental health field. There are two basically different concepts: one is to base both certification and licensing on the professions; the other is to base certification on profession, but to base licensing on function or service. Certification serves the necessary purpose of enabling the public to know that they are forming a contract with a *bona fide* member of the profession. In other words, it makes it possible for the public to identify an individual as belonging to a legally recognized profession. Licensing establishes the right of an individual, based on training and demonstrated competence, to perform a set of services in exchange for a reward. It establishes legal responsibility for misadventure arising out of the service. An interprofessional licensure is especially applicable when, as is the case with the mental health professions, knowledge,

¹⁰S. Freud, "On the Teaching of Psycho-Analysis in the Universities", *Standard Edition*, Vol. XVII, Hogarth Press, London, p. 173.

training, technology and service capability are shared by a number of professions. This advantage can best be demonstrated by considering an anomaly inherent in the present system which has been discussed already in detail at an early stage in this report. At present the general practitioner who, let us assume, has received no adequate training in psychodynamics may nevertheless perform a psychodiagnosis and psychotherapy. But a clinical psychologist who, let us assume, has been thoroughly trained in psychodiagnosis and psychotherapy is required by law to treat patients suffering from "any type of mental disorder" only on "the request of or in association with a duly qualified medical practitioner".

It is compatible with the existing law that the "duly qualified medical practitioner" be a general practitioner without any adequate psychiatric training. Neither is the nature of the relationship between doctor and psychologist defined. In some circumstances the relationship is supervisory with responsibility for the treatment of the patient retained by the physician; in others it is, in practice, merely a formality with responsibility assumed by the psychologist. Thus the necessary relation to guard against medical mischance is not adequately spelled out in the law governing psychological practice, and *the necessary relation to a psychiatrist or psychologist to guard against psychiatric mischance is not recognized at all in the law governing medical practice.*

In fact, in terms of their trained competence, which is the only valid criterion, it would seem more appropriate to require physicians except psychiatrists to treat psychological disorders under the supervision of psychologists. This anomaly could be corrected by detaching the performance of specific therapeutic services from the exclusive possession of a profession, in this case medicine, and licensing its practice only on the basis of demonstrated competence as guaranteed by the completion of an adequate training program and examination. Thus a licensing board could be established to examine and license the practitioners of a number of different professions including medicine, psychology, social work and nursing, when these professionals had undertaken the requisite training and had passed the licensing examinations. Each profession could train its own members in psychodiagnosis and psychotherapy in its own training program or cooperatively, but the standard of training would become interdisciplinary. An individual member of any profession would have to demonstrate his ability to meet the shared standard.

The effect of this arrangement would be that general practitioners or other medical practitioners who had not undertaken the prescribed training would not be able to practise psychotherapy legally. The same legal stricture would apply to psychologists, social workers or any other professional or subprofessional person. Given the intrinsically interprofessional nature of the science and technology involved, it would appear that this system is the more realistic one.

It would remain, of course, that a psychologist licensed to practise psychotherapy could not practise under the same conditions as a psychiatrist or a general

practitioner who had undertaken training in psychotherapy, but would be subject to the specific constraints already discussed (Chapter 4, Chapter 6, Chapter 10, Chapter 11). However, in the interests of realism it should be pointed out also that the safety of the patient would probably be better assured by a psychotherapist working in close alliance with an internist than is sometimes the case when a patient is treated by a psychiatrist who has been out of touch with medical practice for many years. Kubie puts the point well.

Is a patient safer in the hands of a psychiatrist who practises the medicine of 1910, or of a Doctor of Medical Psychology, trained as outlined above, and associated with an internist of 1950? What is the honest and realistic answer to this question? What is more, it will be easy to check the activities of the Doctor of medical psychology, so as to make sure that he is abiding by the law: whereas it is difficult to check up on the doctor of medicine, who can always claim that he has made his own physical examinations, even when these were of a cursory, inadequate and antiquated nature.¹¹

By the same token this form of licensure would meet the criticism which is often levelled by psychiatrists against psychological training, and which gives some justification to their view that psychologists require medical supervision. A Ph.D. in psychology, they rightly point out, does not, per se, equip a psychologist to perform either psychodiagnosis or psychotherapy. His training may have no psychiatric or psychodynamic components whatsoever. Nevertheless, as things now stand he may be registered after one year of practical experience and practise applied psychology. The separation of licensure from certification in the manner outlined would correct this situation.

Although the discussion has been couched in terms of psychodiagnosis and psychotherapy, the same principles could be extended to other professional functions such as personality assessment, hypnosis, social casework, and so on. In each case what would be licensed would not be the services of a profession, per se, but a service, per se. The concept could be utilized for those services that are legitimately interprofessional.

An alternative to interdisciplinary licensure is a stricter application of functional differentiation and training standards within each profession. Thus a licence to practise psychotherapy could be issued to medical doctors properly trained to perform it by a medical licensing body, a licence to practise psychotherapy could be issued to psychologists, equivalently trained, by a psychology licensing body, and so on. Such an arrangement would be a distinct improvement on what now exists. But it would fail to do justice to the genuinely interdisciplinary and interprofessional nature of the service in question. And it would not be able to guarantee a common standard.

¹¹L. S. Kubie, "The Pros and Cons of a New Profession: A Doctorate in Medical Psychology", in *Texas Reports on Biology and Medicine*, Vol. 12, No. 3, 1954, p. 162.

Licensing Boards

Interdisciplinary licensing would require a different type of licensing board. The composition of a certifying board could be properly restricted to the members of the profession in question. But the composition of a licensing board for psychotherapists, for example, should include psychiatrists, psychologists, psychoanalysts, psychiatric social workers, as well as doctors of psychological medicine (when this profession comes into being). However, as indicated earlier, there is also a case for including in the membership of any such licensing board persons who are not members of any of the professions involved and who, while sympathetic to the needs of the professions, could be expected to act as representatives of the public interest in policy discussions and administrative decisions. They could also take a detached attitude towards any interprofessional rivalry that might occur among the professional members of the board. These members, for obvious reasons, should be in a minority but their presence and their right to advance independent viewpoints would be salutary.

The general aim of this and other considerations relating to the mental health professions in this report is to support the development of many more highly trained diagnosticians and therapists, especially among the non-medical professions. Medicine in general, and psychiatry in particular, are now and will continue to be unable to meet demands for mental health services throughout the province. This fact has long since been recognized in the U.S. even though psychiatry, clinical psychology and psychoanalysis are at a much higher level of development in comparable American jurisdictions than they are in Ontario. Therefore, our only recourse is to train more and better non-medical mental health professionals. Then it will be possible to move safely in the direction of option 5) above: the training of subprofessional mental health counsellors.

Before considering this issue, a cautionary note must be given. There is a notion favoured by some, including some psychiatrists, that just about anyone with a modicum of preparation and a great amount of empathy for the difficulties of others can engage usefully in psychotherapy. This is a foolish idea, since, if it had a grain of truth, psychosis would be the only significant mental illness psychoneurosis having been eliminated by natural human intercourse. In fact, most mental illnesses are psychoneuroses which are directly traceable to impaired and impairing parent-child relationships communicated without improvement from generation to generation. It is also a dangerous idea, in that it encourages people to seek help from persons who are not competent to help and who may in fact cause some damage. There is some reason for concern that because of the grave shortage of qualified professionals there will be an increase in the numbers of pseudo-therapists and counsellors. Despite these dangers, some promising, imaginative responses to the manpower problem have been made in the form of training programs for subprofessional therapists and counsellors.

Training of Subprofessional and Non-professional Therapists

Imaginative and constructive work in the training of subprofessional psychotherapists and mental health counsellors undertaken in Ontario and the U.S. has been described elsewhere in this report (Chapter 4, Chapter 8). One difference is striking: the American program is conducted by highly qualified professionals. A program initiated within the Department of Reform Institutions, by contrast, is conducted by a social worker without an M.S.W., who was himself guided by an M.S.W. who had received his training in group psychotherapy in an informal in-service ad hoc training program. Clearly supervision and instruction cannot be what it should be, because there are not enough well-trained diagnosticians and therapists. In such a program, all kinds of hazards can develop despite the best intentions and efforts of all participants, because good intentions and sincere efforts are no substitute for knowledge when dealing with the complex human interactions involved in psychological therapy.

Again, Service Three in New Haven serves as a useful guide. The Director of Service Three is in a much better position to provide the supervision necessary when subprofessional mental health workers become involved in therapy. His large complement of professionals enables him to keep the ratio of professionals to subprofessionals in reasonable balance. It is really only in such circumstances that subprofessional therapists can work safely, for otherwise supervision is only a word. It could be that no treatment at all for psychoneurotic disorders would be more in the interest of the patient than having his problems aggravated by the inept interpretations and interventions of a semi-trained, semi-competent therapist.

However, with increased numbers of well-trained and experienced psychiatrists, psychologists and psychiatric social workers, it should be possible to increase the number of supporting subprofessional workers who can engage in the treatment and counselling of selected patients under supervision. The importance of such a development cannot be exaggerated. It could provide badly needed mental health services in a variety of different contexts, such as centres for the treatment of alcoholics, reform institutions, probation, marriage counselling services and social agencies.

One of these areas, the treatment of alcoholics, has been selected for comment here because an excellent study of the issues involved has already been published by Reginald G. Smart.¹² Smart shows that no substantial inroads into the alcoholism problem can be made without the utilization of subprofessional psychotherapists. A survey of the literature on subprofessional training shows that effective therapists can be produced in this way. Smart concludes that "programs for the selection, training, and recruitment of non-professional therapists are badly needed for the treatment of the mentally ill, especially alcoholics".¹³

¹²Reginald G. Smart, "Mental Health Resources and the Treatment of Alcoholics in Ontario", Alcoholism and Drug Addiction Research Foundation (unpublished paper).

¹³*Ibid.*, p. 11.

The work of Rioch is particularly applicable.¹⁴ Rioch undertook a pilot project to train married women carefully selected for intelligence and therapeutic potential. The training, which consisted of approximately one and one-half years of graduate study, was directed towards the preparation of psychotherapists for adolescents. Independent evaluations of the work of these therapists showed that they had acquired useful skills.

In Ontario there is a growing body of married women who have received a university education, who have made a success of their family life and, in their late thirties or early forties, with children at school all day, find themselves in need of meaningful and challenging work. It would be reasonable to assume that a considerable number of such women in this particular life situation would be attracted to such a training program and could do effective work in providing psychotherapy under supervision to a wide variety of persons — from alcoholics, to persons in need of help with the problems of their marriage, delinquent adolescents, and so on. It has been pointed out by Smart that there is a large group of trained nurses who no longer practise nursing.¹⁵ It is possible that the major reason for discontinuing their nursing work, in a fair number of cases, is the incompatibility of shift work in nursing with married life. If so, some of these nurses might welcome an opportunity to develop mental health therapeutic skills in order to be able to work, perhaps on a half-day basis, in an outpatient service. There is a substantial, unused resource of well-educated and trained women in the province who would have no aversion to working under supervision and who could, with training, become highly competent mental health counsellors or even psychotherapists for selected patients and thus substantially improve the level of available resources.

Adequate safeguards would have to be established to guarantee that sub-professional or non-professional mental health counsellors would work within the limitations imposed by the nature and extent of their training. These safeguards could be achieved by adding certain conditions to those that obtain for non-medical mental health professionals. Two further conditions would be needed: 1) such therapists would be permitted to treat only selected patients — the selection being made by a mental health professional who is fully trained in psycho-diagnosis; 2) such therapists could treat patients only under the supervision of a mental health professional who is fully trained in psychotherapy. Consequently, these therapists could not work in private practice, unless in a private group

¹⁴M. J. Rioch, C. Elkes, A. F. Arden, "Pilot Project in Training Mental Health Counsellors", U.S. Department of Health, Education and Welfare Publication, 1965. Also, M. J. Rioch, "Implications of Two Pilot Projects in Training Mature Women as Counsellors", American Psychological Association Symposium, Chicago, September 1965; and W. Schofield, "Psychotherapy: The Purchase of Friendship", Prentice-Hall, Englewood Cliffs, N.J., 1964.

¹⁵Reginald G. Smart, *op. cit.*, p. 5.

practice operated by fully qualified and licensed mental health professionals who would be in a position to undertake the selection of patients and the continuous supervision that is necessary.

Under these conditions the training of a body of subprofessional mental health counsellors would have a secondary gain for society. It would increase the number of persons in our community who have a sound grasp of some range of mental health problems, who have a capacity to deal effectively with them, and who are familiar with the treatment resources available. The presence of increased numbers of such persons would, as Service Three in New Haven has already demonstrated, greatly improve the communication and interrelationships of mental health services with the community and it would be a major step towards achieving the objectives of community psychiatry.

However, a number of problems arise out of any such scheme. Is it really the case that married women with B.A.'s, retired nurses, early school leavers with high intelligence and mature personalities can be trained in relatively (as compared with professional training) short periods of time to be effective mental health counsellors? If so, does the training of professional psychotherapists require the educational prerequisites and the time now demanded? Is there a valid distinction between counselling and psychotherapy? Is psychotherapy a professional service at all?

There are members of the mental health professions who do hold the view that psychotherapy is not intrinsically a professional service, but that it is a latent natural talent in some people. They feel that unless it is already present, no amount of training will enable an individual to develop it. These members of the mental health professions support the idea of training subprofessional psychotherapists and mental health counsellors, seeing the role of the professional as increasingly one of supervision and consultation. Yet other members of the mental health professions take the opposite view. They oppose the training of subprofessional counsellors because they feel that it threatens their own claims to the status of a professional based on their expertise in psychotherapy. Underlying this reaction is also the idea that psychotherapy is not intrinsically a professional activity.

However, if one reflects on the history of the treatment of mental illness in our civilization, and on the inadequacies and difficulties people encounter in dealing with even minor psychopathology in themselves and others, one quickly appreciates how essential an intensive, professional training for the psychotherapist is, before he can be relied on to use any natural talents he may have for rendering effective help to persons suffering from a neurotic disability. Consequently, this work can be safely shared only with subprofessional therapists when they are

trained by professional psychotherapists, when the limits of their activities are defined by professional psychotherapists through the selection of patients, and when their therapeutic work is carried out under the close supervision of professionals.

The general uncertainty about this problem is reflected in the words used to denote the activities of these subprofessional therapists. Some use the word "psychotherapy" to describe it and call them "psychotherapists"; others use the word "mental health counselling" and call them "mental health counsellors". Indeed, since the medical profession has laid claim to the word "psychotherapy" by defining psychotherapy as a medical act, it has become the practice of psychiatrists to say that clinical psychologists who are practising psychotherapy are engaged in "mental health counselling". This terminology must be rejected as an instance of word magic. There is no real difference between "mental health counselling" by a psychodynamically trained psychologist and psychotherapy by a psychodynamically trained psychiatrist. The practice of referring to psychotherapy dispensed by psychologists as counselling will not change the nature of the psychologists' activity; it will only add to existing public confusion concerning mental health services and the professionals who are equipped to dispense them. Conversely, persons who are trained to engage in mental health counselling and provide nothing but mental health counselling to their clients may use the term "psychotherapy" to denote this activity and thus misrepresent it. It can be reasonably argued, then, that many self-professed non-professional psychotherapists are not psychotherapists at all and are not competent to practise psychotherapy.

This issue cannot be decided here. Nor can it be decided simply on the basis of the competing claims of professional groups. It can be rationally decided only on the basis of a scientific differentiation between mental health counselling and psychotherapy, and a clear delineation of the knowledge and training necessary for each. If it turns out that subprofessionals of the type described above can, with requisite training, engage in a successful psychotherapeutic relation with patients under supervision, then realism and accuracy require that the term "psychotherapy" be used to designate their work.¹⁶ If, on the other hand, any professional or subprofessional person is trained only to engage in mental health counselling, then his work should bear that label whether he is a physician, psychiatrist, psychologist, social worker or subprofessional mental health worker. The mental health professions owe it to the public to do everything in their power to keep these terms as clear and realistic in their use as possible. They should not be used as weapons for the conduct of interprofessional rivalry. Legislation which uses these terms should be based on the recommendations of a team

¹⁶Max Pepper applied the term "psychotherapy" to the work of his subprofessional treatment staff in the outpatient department of his clinic.

composed of a psychoanalyst, psychiatrist, psychologist and psychiatric social worker who are experts in psychodiagnosis and psychotherapy, and who are prepared to make recommendations on the basis of their scientific knowledge and not on the basis of their professional affiliations.

The field work for this report suggests that the preponderant view among mental health professionals supports the idea of training subprofessional therapists and mental health counsellors to fill the great gaps in the province's mental health services, so long as the kind of safeguards discussed above are present.

A number of experiments in the training of subprofessional and non-professional therapists are already under way. A well-planned deliberate program of pilot projects in a variety of different mental health settings is now needed with adequate financing and professional direction. Thus far these projects have been largely ad hoc and dependent on the initiation and imagination of single individuals. Stable financial, professional and institutional support is needed, as well as independent evaluations of their worth. The natural setting for these programs is the teaching hospitals and clinics, because the training should be service-oriented.

Licensing and Interprofessional Services

Obviously if unlicensed subprofessionals can be trained to do psychotherapy, the licence to practise it should not be the monopoly of any profession. This notion applies more generally to a range of specific services that may be performed by several different professions, by the mental health professions alone or others as well. An example is psychological testing. A school teacher may administer a routine psychological test to provide herself with data to improve the effectiveness of her teaching and her management of a classroom. Under the New Brunswick Legislation "which specifies that individual assessment must be carried out by a psychologist or under the supervision of a psychologist", a teacher who had some training in the use of psychological tests could not legally undertake to use them.¹⁷ In the view of Raymond Berry, what is at issue should not be the exclusive use of some instrument or technique by a profession, but who can safely use it for certain purposes.

If the public needs protection in the area of psychological assessment for example, Legislation might be enacted under a psychological assessment Act indicating those groups who could test and under what circumstances and for what purposes. Those are the key issues:—

who can carry out what procedures under *what* circumstances and *why*. I am loathe to endorse a position such as that taken by the New Brunswick Legislation which specified that individual assessment must be carried out by a psychologist or under the supervision of a psychologist since such

¹⁷Raymond Berry, "Psychology and the Law", Canadian Psychological Association, Annual Meeting, Calgary, June 1968, p. 9.

general statements are going to lead to difficulties of interpretation. I am not concerned about the control of individual testing. But I am concerned about the reasons individual assessment is undertaken and the decision to be made relative to it. The greater the effect of the decision upon the life of the subject, the more careful we must be about safeguards, controls and protection. When a decision is to be made to place a person in some special program, of residential training or treatment, or perhaps to remove his rights or even remove him from society, we have a responsibility to see that psychological knowledge is not misused and to ensure that the individual has the right to the best we have to offer in making judgements so crucial to him.¹⁸

What is indicated, then, in an era of expanding and overlapping science and technology, is a licensing system that will not create a professional monopoly on those services which can be genuinely shared by different professions but will provide the necessary safeguards based on limitations on the use of these services. Thus a teacher should not be denied the right to use psychological testing techniques when an error in their use would not have serious ill consequences, but should not be allowed to use them for the purpose of deciding whether or not a student will be placed in a special class for emotionally disturbed children. Uses of this nature should be limited to a psychologist who is an expert in the use of psychological tests, or to a psychometrist working under the supervision of such a psychologist. This position, which has been elaborated and advocated by Berry, seems to be a reasonable one, although the formulation of the conditions would be complex and would require the advice of experts.

The Alternative of Limited Licence

There is, as we pointed out above, an alternative conception to the licensing of services per se, when these services are within the trained competence of diverse professions. This is the concept of a limited licence. Limited licence would modify the current concept of licensing by introducing specific exclusions of services not deemed to be within the trained capability of the practitioner. Thus a psychologist who has been trained as an educational psychologist and who has not been trained in psychodiagnosis and psychotherapy would, according to this concept, be licensed to undertake testing, planning of special classes, and services of this type to remedy learning problems not arising out of or associated with psychopathology; but he would not be entitled to perform a psychodiagnosis or psychological therapy. He would be required to refer students in whom a psychopathological disturbance was suspected to a psychologist or other mental health professional trained in psychodiagnosis and psychotherapy. Similarly, a general practitioner who had not received specific and sufficient training in medical psychology would be subject to the exclusion of the provision of these diagnostic and treatment services from his licence.

¹⁸*Ibid.*, pp. 10-11.

The adoption of either service licensing or limited licensing would have three salutary effects on mental health services.

- 1) It would give legal support to the truth that some professionals as well as some laymen have difficulty in accepting that psychodiagnosis and psychotherapy are forms of expertise which untrained persons cannot be expected to have, whether or not they are professionally trained in some other field and whatever the level of their natural intelligence.
- 2) It would protect the public from the frustration leading to passive despair which results when they seek, and are led to believe that they can obtain, mental health services from professional or other persons who are, in reality, not properly equipped by trained experience to give them. The impact of such experiences generates the conviction that no solution for the problem is available and that no therapies are efficacious in bringing about improvements. These attitudes leave unimproved psychopathological conditions that could be improved, with the inevitable result that the individuals in question, if they are parents for example, will perpetuate their own psychopathology in their offspring. Thus potential improvements in the general levels of mental health in our families and our communities are perpetually delayed.
- 3) By establishing clear limits of practice based on training, professional persons who encounter mental health problems in their patients and clients will know to whom they should refer a patient or client. This factor applies especially to the cooperation between medicine and psychology. The most effective mental health services that could be mobilized in the province in the foreseeable future will have to involve close cooperation between medicine and the non-medical mental health professions. As long as physicians who have neither the training nor the time for the effective practice of medical psychology are able to function as though they did, this cooperation is unlikely to develop. Ideally what is needed is several hundred more psychologists, social workers and non-medical psychotherapists thoroughly trained in psychodiagnosis and psychotherapy, and working in close association with doctors throughout the province in hospitals, clinics, special services and private practices.

The Alternative of "Free" Competition

The alternative, of course, is to abandon licensing altogether or to provide ambiguous generalized licences to the professions to practise their profession, leaving relatively undefined what exactly the practice of the profession is. This system would generate free competition among the professions and the public

could be expected to seek services from the professions that developed the best and least costly technologies. There are two decisive objections to this alternative.

- 1) It is necessary that there be cooperation between medicine and non-medical mental health professions in the diagnosis and treatment of all patients treated by non-medical mental health professionals. Such a condition prevents free competition among the professions.
- 2) As OMSIP currently functions, it provides insurance coverage for services received from a profession rather than coverage for services as such. As long as this situation obtains, there can be no free competition among mental health professions.

It will be noticed that both conditions give medicine overwhelming advantages vis-à-vis other professions. Consequently, if there is no regulation and if there is no planning for the expansion of the non-medical profession in mental health, it is predictable that medicine will gradually occupy the entire field; such few members of other professions as continue to take an interest in mental health will find themselves in an increasingly ancillary role. Such a development would not be in the best interests of the province's mental health services.

Financing Mental Health Services

OMSIP is basically an insurance scheme for the services of a profession. Exemptions to this generalization occur but they are, so far, few. Attitudes of psychologists to this situation have been surveyed (Chapter 10), and certain anomalies generated by it have been described (Chapter 6, Chapter 10). These anomalies can be corrected by a single step: by insuring the service, rather than the profession that provides it. If, then, psychodiagnosis and psychotherapy are inter-professional services (and they are), then these services provided by properly qualified individuals should be subject to insurance coverage irrespective of whether they are provided by a psychiatrist, psychologist, social worker, psychoanalyst or professional psychotherapist.

Unless such a modification is made in OMSIP, the non-medical professions will find it increasingly impossible to survive except in salaried positions in hospitals and clinics run by doctors and financed by the Department of Health, and to a lesser extent in general hospitals. Nothing could be more prejudicial to the growth of strong non-medical mental health resources in the province — something that the people of the province very much need.

Delivery Systems in Mental Health

The existing delivery system for mental health services is highly heterogeneous. It has developed without any overall plan in response to both changing demands in various sectors of society and changing therapeutic capabilities in psychiatry and psychology. The core of the system is the Ontario Hospitals and outpatient

clinics operated by the Department of Health. These provide, for the most part, long and short-term hospital care and treatment for the severest forms of mental illness — psychosis, retardation, brain damage — although the outpatient clinics also provide treatment for neurotic disorders and character and behaviour disorders. This core has been supplemented recently by the expansion of the number of psychiatric wards and outpatient services in general hospitals. By and large these provide short-term treatment for psychotic and severe neurotic disorders.

There is also the Clarke Institute, which provides approximately the same range of treatment and diagnostic services as the psychiatric inpatient and outpatient service of a general hospital and also is administered like a general hospital. Its similarity with the Ontario Hospitals consists in the fact that it treats only psychiatric cases.

Next, there is the private practice of psychiatrists, psychoanalysts and psychologists. Some experimentation with group private practice, including interprofessional group private practice, has been reported. These experiments failed because of the inequalities of fee for service. Practically all private practice is solo practice and it is almost all conducted by psychiatrists, medically trained psychoanalysts and a few psychologists.

As data already reported show, frequently psychiatrists will combine some hospital practice with private practice. Relatively few psychiatrists devote all their professional work to private practice (Table 4.20). The private practice of psychiatry is devoted largely to the treatment of psychoneurotic disorders and the milder forms of character and behaviour disorder, although psychiatrists in private practice also treat, on a long-term basis, persons with fluctuating psychotic conditions which are not so severe as to require hospitalization, or which require hospitalization only periodically. Finally, there are special services such as treatment (day and residential) centres for emotionally disturbed children, the mental health services of the Department of Reform Institutions, psychological services in the school, family service agencies and Children's Aid Societies. Some of these services involve both diagnosis and treatment; others are limited almost entirely to diagnosis.

Two Strategies for Growth and Development

There are two basically different strategies for expanding the scope of these services and improving their quality. One is to work within the existing heterogeneous structure and to train many more professionals to work within it. The other is to modify the structure of the system by unifying a group of heterogeneous services on a community basis.

Preservation of the Existing System

Improvements within the existing system could unquestionably be effected. By training more psychiatrists, psychoanalysts, psychologists, psychiatric social

workers, psychiatric nurses, subprofessional therapists, occupational therapists and substantially improving rehabilitation programs, the Ontario Hospitals would no longer have to be as restricted as they now are to the care and custody of the chronically mental ill. Perhaps even more important, by training many more mental health professionals — both medical and non-medical — who are able to engage in private practice, and by encouraging full cooperation between doctors and non-medical mental health professionals, quite substantial gains could be made on all fronts. If there were many more psychiatrists, psychoanalysts, and psychologists in private practice, not only could more private patients be serviced but public and private agencies such as the courts, the schools and Children's Aid Societies could compete more successfully for the consultative, diagnostic and therapeutic services they need.

Comprehensive Community Mental Health Centres

The second alternative, however, has much to recommend it. A partial model is provided by the Community Mental Health Centres now being rapidly developed throughout the United States under Public Law 88-64. Centres of this type would have the advantage of serving limited specific catchment areas and would be able to establish useful and effective relationships with the communities they serve. They could provide a full range of coordinated mental health services to the community, not only to adult psychotic and neurotic patients but also to emotionally disturbed children and adolescents, to delinquent adolescents, alcoholics, minor offenders, children with learning and behaviour difficulties in school resulting from developmental or relationship problems, and to the aged in the retirement homes of the area.

The Ontario Committee on Taxation has already suggested the organization of the province into regional government units to provide units that are more efficient than the counties and municipalities and that are also closer to the communities and the lives of individuals than the provincial government.¹⁹ These regions are classified into three types: metropolitan, urbanizing and county. It just happens that these regions could function well as catchment areas for community mental health centres, with regard to geographic size, population size and demographic properties. The only exceptions would be some of the metropolitan regions, whose populations in some cases greatly exceed 200,000 persons. But these could be conveniently subdivided, so as to provide adequately circumscribed catchment areas.

Numerous benefits could accrue from such centres. Some of these benefits have already been presented in another context and will not be repeated here (Chapter 12, Chapter 13, Chapter 14, Chapter 15, Chapter 17), but others are worth specific mention.

¹⁹*Report of the Ontario Committee on Taxation*, Vol II, Queen's Printer, Toronto, 1967. pp. 509-550.

- 1) Such centres might attract badly needed professional persons to rural and outlying urban areas of the province. The location of a number of professionals in one area would offset the threat of professional isolation. The existence of a multi-faceted service in which professionals would not be dealing *only* with character and behaviour disorders associated with delinquency or criminality, or *only* with problems of alcoholism, or *only* with hospitalized illnesses, would also make working in such centres a more attractive professional prospect. If adequate funds for research were also available to professionals associated with these centres, another incentive would be added. If these premises are sound, and field interviews have indicated that they are, then the creation of a province-wide system of mental health centres with geographically well-defined catchment areas might go some way towards removing some of the inequalities in the availability of mental health services in the province which have been documented in this report (Chapter 4, Chapter 6, Chapter 9, Chapter 12, Chapter 14, Chapter 15).
- 2) Community mental health centres charged with the responsibility of training local professional and subprofessional mental health personnel, and funded for this purpose, could provide valuable practicum and residence settings for professional training as well as training centres for subprofessional and non-professional therapists drawn from the catchment area itself. These persons would reinforce the work of the centre through their membership in the community. A community mental health centre with a full complement of professional staff would provide natural settings for the work of subprofessional therapists.
- 3) It has been argued by some psychiatrists interviewed that group practice has two distinct advantages; a) relatively young and inexperienced psychotherapists (e.g., psychiatric residents) can do effective therapy with ample opportunities for consultation with senior psychiatrists; b) the constant interactions and independent evaluations of diagnostic and therapeutic work, as well as theoretical formulations with and by professional peers, provide an invaluable safeguard against inadequate standards of work and the development of idiosyncratic practices and theories. Ongoing group reality testing is thought by these psychiatrists to be more effective for these purposes than individual reality testing. More effective treatment and better safeguards for high professional standards could be expected.
- 4) Prevention, rehabilitation and public education programs could be carried out more effectively as a result of the reduction of the scale of these activities to more manageable proportions. It would be

easier to do more effective long-term local planning; and it would be easier to receive feed-back concerning the success of programs.

- 5) Community mental health centres could provide diagnostic services to the courts in their catchment areas, thus eliminating the need for a costly, special diagnostic service operated by the Department of Reform Institutions and requiring specialized staff difficult to obtain.
- 6) Community mental health centres could provide the special diagnostic, treatment and supervisory services necessary for the utilization of child care workers or other subprofessional mental health workers in cottage-type residential units for emotionally disturbed children. They would also have the advantages of being able to maintain the child, whenever possible, in his own neighbourhood and school or one similar to it, and in close relationship to his family when desirable. The treatment of the family, when necessary, also would be more practical. A residential unit for emotionally disturbed children could be a specialized sub-unit within the centre.
- 7) Integrated mental health centres could provide much more effective diagnostic and treatment services than can the disconnected and separated services that now exist. A not untypical example will reveal the inadequacies in the present system. A child of eight living in Barrie has behaviour problems at school. These problems are investigated by a school social worker and are found to be related to the fact that he has alcoholic parents. The problems grow worse, and he becomes the ward of a Children's Aid Society. He and his family are diagnosed again by professionals attached to the Children's Aid Society. He is placed in a foster home, but his behaviour problems continue. At fifteen he is a chronic truant from school and becomes involved in the theft of an automobile. He is sent to a training school in another part of the province. Preliminary to his placement there, yet another psychological assessment is made. After leaving the training school he manages to live more successfully for a time, becomes steadily employed, marries but then develops alcoholism. He attends an alcoholic clinic, where he is again diagnosed and given a psychological assessment. One need not continue the dreary history in order to appreciate two facts about the functioning of our current system.
 - a) An individual may, over a period of years, from childhood to adulthood, be the subject of several major efforts to diagnose and assess his problems by several different agencies — the schools, the Children's Aid Societies, the courts, the Department of Reform Institutions, the Department of Health — without there being any effective intercommunication among the professionals who have

seen the individual and have attempted to assess his problems.
b) An individual may be subjected to this series of diagnoses assessments without their ever leading to any effective treatment. By integrating all public mental health services at the community level, the first problem at least could be largely solved and a first step towards solving the second problem would be taken.

- 8) The community mental health centres could be associated with more comprehensive community health centres, so as to provide a broad range of health services to well-defined catchment areas. Experiments with such services with a view to determining their success in solving problems of prevention are already under way, notably in Cambridge, Massachusetts under the direction of the Harvard Medical School. This second level of integration of mental health services with health services generally would have the advantage of relating the non-medical mental health professionals to doctors in an institutional environment in which the collaboration and co-operation among them could easily take place. On the other hand it would have to be established that medicine could not dominate the mental health services to the detriment of the involvement of the non-medical mental health professions.

It is clear that this grass-roots integration of mental health services would require a change in the structure of government itself. An integrated community mental health service would require close cooperation among at least four government departments — Health, Social and Family Services, Education and Reform Institutions — in order to make sure that the needs of each department for mental health services were being met according to an acceptable set of priorities. Horizontal integration of services at the community level entails horizontal integration of planning at the provincial level, if it is to work.

There are two philosophical issues involved in any decision concerning the kind of mental health services the province should have. It is human to deny the fact of mental disorders. This denial may take many forms, from gossip, to laughing it off, to angry rejection. But in every case, denial results in a distorted perception of reality and an irresponsible attitude. Psychopathology is not limited to the grossly mentally ill; it is part of every human growth process and it is a common phenomenon of everyday life. The present system of mental hospitals and psychiatric wards tends to cooperate with the need to deny the realities of mental illness and mental health, and thus tends to encourage rather than correct distorted perceptions of the problem and attitudes of irresponsibility. If mental health services were decentralized and rooted firmly in the community, the opposite tendency would occur: our institutions would tend to generate more realism and responsibility among the public for the care of the mentally ill. Informed concern

about mental health means not only more community involvement in rehabilitation and prevention, but more individual involvement in prevention through the struggle to improve the quality of family life.

From the social point of view there is a growing danger that urbanization, professionalization and bureaucratic centralization will lead to the construction of larger and larger institutional structures, providing services in highly artificial environments in isolation from our neighbourhoods where the problems are generated and in which, ultimately, solutions must be found. The Department of Reform Institutions' plan for a provincial diagnostic centre for criminal offenders to provide psychological and psychiatric assessments to the courts is an example of this process. One of the effects of this development will be the further depletion of professional resources in our rural communities and the further impoverishment of their social and cultural lives. Thus, in the interests of healthy equitable social development in the province this tendency should be resisted. If it is not resisted, there will emerge in Ontario a dangerous alienation of service resources from the people. The creation of community mental health centres would provide some of this salutary resistance to the alienation of people from institutions and institutions from people.

Consequently, it would be highly desirable to have a number of pilot projects undertaken to test out the feasibility of community mental health centres in rural and urban communities.

A positive approach to mental health will be increasingly justified on practical grounds as science and technology come to play a more and more important role in all aspects of society. A technologically advanced, prosperous society in competition with other technologically advanced societies cannot afford to have a large number of its professional and business community suffering from alcoholism, for example, or more generally from impairing psychopathology. Thus, increasingly, success in intersocial competition will go to those societies that progress beyond providing custodial care, and limited treatment and rehabilitation for those relatively few individuals who suffer from gross mental illness, to the effective treatment of significantly impairing psychoneurosis and prevention. To this economic and historical premise there may also be added the logically independent humanistic premise that the goal of each individual life should be dedicated as far as genetic inheritance and the general conditions of life permit, to the achievement of the ancient ideal of a healthy mind in a healthy body. Modern psychiatry, psychoanalysis, psychology and sociology should be mobilized so as to help individuals achieve that ideal. From its achievement many benefits will flow to many people in these generations and those to come.

Appendix

A part of the research for this report consisted of questionnaire surveys of psychiatrists (Study 2), physicians (Study 3), psychologists (Study 4), school (Study 5) and university mental health services (Study 6), inpatient (Study 7) and outpatient services (Study 8) for children. The instruments used for these surveys are listed below. The example of the questionnaire to physicians is one that was sent to general practitioners, but those sent to medical specialists were identical with it.

Questionnaire A was sent to Psychiatrists; Questionnaire B to general psychologists; Questionnaire C to general practitioners, surgeons, orthopaedic surgeons, neurologists, internists, obstetricians and gynaecologists; Questionnaire D to school boards and university health services; Questionnaire E to outpatient clinics; Questionnaire F to inpatient clinics.

The Ontario Medical Association provided the mailing list for psychiatrists and physicians, and the use of their addressing facilities. This solution to the practical problem of administering the questionnaires (they were all administered by mail rather than interview) influenced the nature of the population of psychiatrists and physicians. Physicians who were not members of the Ontario Medical Association were excluded. The OMA mailing list on psychiatry is "open" and thus included physicians who are not psychiatrists. There were few respondents who were not either psychiatrists or residents in psychiatry. For the purpose of the tabular analysis of the questionnaire data, returns from these respondents were excluded. It is unlikely that a bias was introduced into the data deriving from the exclusion from the population of physicians who were not members of the OMA. Ninety per cent of Ontario's physicians are members of the OMA. It is not likely that experiences, attitudes and views concerning questions of mental illness, treatment and services are significantly correlated with the choice not to be a member of the OMA.

A questionnaire was sent to every physician on the OMA psychiatric list. A sample was selected of the populations in the OMA lists of general practitioners, neurologists, general surgeons, orthopaedic surgeons, internists, gynaecologists and obstetricians. The sample size in each case was established by a standard formula which guaranteed a valid distribution, within the sample, of each type of physician and of metropolitan as compared with non-metropolitan practitioners.

The questionnaires to psychologists were restricted to registered psychologists working in applied fields. Questionnaires were not sent to psychologists who were

devoting all of their time to teaching and research at a university. Registered psychologists who held university appointments and also worked in an applied setting were included.

The questionnaires to school boards were sent to urban inspectorates only. The same questionnaire was sent to the health services of Ontario's fifteen universities.

Questionnaires on inpatient services were distributed to Ontario Hospitals, general hospitals, the Sick Children's Hospital, and residential treatment centres listed under Schedules Three and Four of the Department of Social and Family Welfare, as well as certain boarding homes and private clinics.

Questionnaires on outpatient services were sent to similar categories of institutions. They are listed and follow the questionnaire below.

The returned questionnaires were coded and the data on them were then transferred to IBM cards by the Health Data Centre. The programs for the analysis of the data derived from the physician's questionnaires were designed by D. McGowan of the Health Data Centre. The Health Data Centre's computers were used to produce the analyses. Some secondary analyses were done to determine certain questions concerning the reliability of the data — for example, the distribution of reports concerning the number of patients with psychiatric disorders seen and the geographical distribution of the sample. These checks indicated that the sample was adequate.

The data on the questionnaires to psychologists and psychiatrists were also key punched by the Health Data Centre, then programmed and computer-analyzed at Yale University, New Haven.

The data on the questionnaires to school boards, university health clinics, inpatient and outpatient services for emotionally disturbed children were analyzed without the use of a computer.

On the whole, the responses to the questionnaires, especially by individuals, suggest the existence of many practitioners throughout the province who are concerned about inadequacies in the present system and who have constructive ideas about its improvement. Survey research might well be used by the Department of Health to collect these ideas systematically and to maintain a continuing surveillance of the evolution of the system. The complaint that nothing ever comes of these studies was not infrequently voiced. It is hoped that such will not be the fate of this one.

QUESTIONNAIRE ON PSYCHIATRIC SERVICES IN ONTARIO FOR PSYCHIATRISTS

The information contained in this questionnaire will be held strictly confidential. Figures released will be aggregated. No individual statistics will be used.

1. Place of birth:
2. Age and Sex:
3. Place of residential training:
4. Date of last year attended:
5. Undergraduate universities and dates:
6. Medical schools and dates of graduation:
7. (a) Numbers and types of certification:
- (b) Nature of current additional training, if any:
8. (a) Number of hours per week spent in psychiatry and related fields:
- (b) Percentage of time spent in:
 - (a) clinical practice%
 - (b) administration%
 - (c) teaching and research%
 - (d) private practice%
 - (e) other (specify)%
9. (a) Number of cases per week:
- (b) How many patients are on your waiting list?:
10. Please read entire question before answering.

Method of treatment (where more than 1 method of treatment is used, select the principal methods)	Nature of disorder treated by this method, where applicable, e.g., psychosis, psychoneurosis, etc.	No. cases per week	Average duration of treatment
(1) Psychotherapy			
(a) individual	_____		
(b) group	_____		
(2) Psychoanalysis			
(3) Counselling			
(a) individual	_____		
(b) group	_____		

10. Continued.

Method of treatment (where more than 1 method of treatment is used, select the principal methods)	Nature of disorder treated by this method, where applicable, e.g., psychosis, psychoneurosis, etc.	No. cases per week	Average duration of treatment
(4) Narco-analysis			
(5) Insulin shock			
(6) E.C.T.			
(7) Surgery			
(8) Behaviour			
(9) Hypnotism			
(10) Drug therapy			
(11) Play therapy			
(12) Milieu			
(13) Drug & individual therapy			
(14) Drug & group therapy			
(15) E.C.T. & drug therapy			
(16) Milieu & individual therapy			
(17) Milieu & drug therapy			
(18) Milieu & drug & E.C.T.			
(19) Other single therapies (specify)			
(20) Other combinations of therapies (specify)			

11. Major interests:

	Yes	No
(a) general psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(b) psychoanalysis	<input type="checkbox"/>	<input type="checkbox"/>
(c) child psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(d) mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
(e) community psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(f) forensic psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(g) industrial psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(h) public health	<input type="checkbox"/>	<input type="checkbox"/>
(i) family psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(j) adolescent psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(k) education and training	<input type="checkbox"/>	<input type="checkbox"/>
(l) other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

11. (a) Would you prefer to spend more time than the demands of your practice currently permit working in the field(s) of:

(a) general psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(b) psychoanalysis	<input type="checkbox"/>	<input type="checkbox"/>
(c) child psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(d) mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
(e) community psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(f) forensic psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(g) industrial psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(h) public health	<input type="checkbox"/>	<input type="checkbox"/>
(i) family psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(j) adolescent psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(k) education & training	<input type="checkbox"/>	<input type="checkbox"/>
(l) other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

12. In your opinion, is a medical degree a prerequisite for:

(a) diagnostic work in psychiatry	<input type="checkbox"/>	<input type="checkbox"/>
(b) psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>
(c) psychoanalysis	<input type="checkbox"/>	<input type="checkbox"/>
(d) milieu therapy	<input type="checkbox"/>	<input type="checkbox"/>
(e) behaviour therapy	<input type="checkbox"/>	<input type="checkbox"/>
(f) play therapy	<input type="checkbox"/>	<input type="checkbox"/>
(g) counselling	<input type="checkbox"/>	<input type="checkbox"/>
(i) individual	<input type="checkbox"/>	<input type="checkbox"/>
(ii) group		

13. In what percentage of cases do you use the services of:

(a) Psychiatric Social Workers:

(i) No. of cases for	Clinical practice	Private practice
i. Diagnostic tasks	%	%
ii. Therapeutic procedures		
iii. Other types of general care		

(ii) Would you use these services more if more personnel were available?

Yes ☐

No ☐

(b) Clinical Psychologists:

(i) No. of cases for	Clinical practice	Private practice
i. Diagnostic tasks	%	%
ii. Therapeutic procedures		
iii. Other types of general care		

(ii) Would you use these services more if more personnel were available?

Yes ☐

No ☐

(c) Other (specify):

(i) No. of cases for	Clinical practice	Private practice
i. Diagnostic tasks	%	%
ii. Therapeutic procedures		
iii. Other types of general care		

(ii) Would you use these services more if more personnel were available?

Yes ☐

No ☐

14. (i) Should these services be dispensed *only* upon referral?

	Yes	No
(a) psychiatric social workers	<input type="checkbox"/>	<input type="checkbox"/>
(b) clinical psychologists	<input type="checkbox"/>	<input type="checkbox"/>

(ii) What indications or criteria do you use to refer a patient to a

(a) social worker?

(b) clinical psychologist?

15. In your opinion, should a medical doctor with no psychiatric training beyond medical school:

	Yes	No
(a) practise psychotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
(b) prescribe psychotropic drugs?	<input type="checkbox"/>	<input type="checkbox"/>

16. How would you rate the facilities in the province for training:

(a) psychiatrists?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
(b) psychotherapists?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
(c) psychiatric social workers?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
(d) clinical psychologists?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
(e) psychiatric nurses?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>

17. Is there a need in Ontario for facilities for psychoanalytic training?

Yes ☐

No ☐

18. In your opinion, what type of mental health personnel are most needed in the province? (Rank in order of urgency of need)

.....

.....

19. (a) What percentage of the patients you treat suffer from:

- | | |
|---|--------|
| i. psychosis |% |
| ii. psychoneurosis |% |
| iii. character and behaviour disorders |% |
| iv. disorders arising from organic causes |% |
| v. other (specify) |% |

(b) If, for either theoretical or practical reasons, you feel that the above classification is not valid, would you, *in addition*, list the categories you feel are most meaningful, and fill in the requested information.

20. What percentage of your cases are referred by:

Welfare agencies, including:

- | | |
|-------------------------|--------|
| (a) relief |% |
| (b) family agencies |% |
| (c) children's agencies |% |
| (d) government agencies |% |
| (e) other |% |

Health agencies:

- | | |
|--------------------------------------|--------|
| (a) family physician |% |
| (b) other (specify major categories) |% |
| Education agencies |% |
| Courts, probation officers |% |
| Self or family of patient |% |
| Other |% |

21. A brief enumeration of the qualities and qualifications integral to the competence of a practising specialist in your field:

22. (a) How successfully do you feel communication and co-ordination have been achieved among professions in the mental health field?

Excellent ☐ Good ☐ Fair ☐ Poor ☐

- (b) What are the main obstacles to better co-ordination and communication?

23. General Comments:

Your co-operation and assistance in completing this questionnaire is sincerely appreciated. Please return it as soon as possible in the enclosed envelope to:

Professor Charles Hanly, Project Director,
c/o Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario

SURVEY OF PROFESSIONAL PSYCHOLOGISTS FOR THE COMMITTEE ON THE HEALING ARTS

In order to make this a confidential survey, you are requested NOT to write your name on the questionnaire.

INSTRUCTIONS: Please check in the space provided those answers which reflect your opinion. Where response categories are not provided, please answer as specifically as possible.

1. Age:..... 2. Sex:.....

3. Number of years of practice in the profession 4. Date of registration.....

5. TRAINING:

	(a) Name of university	(b) Date of graduation	(c) Degree conferred
(1) Undergraduate:

(2) Graduate

(3) Internship:	(a) Type of program (e.g. clinical, educational, etc.)	(b) Name of hospital or agency	(c) Duration (from..... to.....)

6. Did your formal training include the following under supervision?

(1) counselling?	Yes <input type="checkbox"/>	How many supervised cases?
	No <input type="checkbox"/>	
(2) case-work?	Yes <input type="checkbox"/>	How many supervised cases?
	No <input type="checkbox"/>	
(3) psychotherapy?	Yes <input type="checkbox"/>	How many supervised cases?
	No <input type="checkbox"/>	

7. In what type of setting do you work?

Setting	(a) Principal employment	(b) Secondary employment
(1) psychiatric hospital
(2) general hospital
(3) clinic (mental health and child guidance)
(4) special clinic (forensic, alcohol & drug addiction)
(5) reform institution
(6) rehabilitation centre
(7) student counselling service
(8) school system
(9) community agency
(10) university
(11) research institute
(12) industry
(13) group private practice
(14) individual private practice
(15) other (please specify)

8. If your primary employment is on a salaried basis, please indicate:

(a) Your designation:

(b) Your salary scale:

9. (a) Do you consider yourself to be involved in the Mental Health field?

Yes ☐ No ☐

(b) Do you consider your training to be directed to service in the Mental Health field?

Yes ☐ No ☐

10. In your primary employment, how many cases do you handle in a week?

(1) new cases:

(2) ongoing cases:

Total:

11. Considering an average of a 40 hour week, how many of those hours do you spend on:

	No. of hours
(1) Administration:	
(a) policy decision on mental health programmes
(b) day-to-day responsibility for operation of service
(2) Analysis and Classification of behaviour (tests & assessments)
(3) Modification of Behaviour
(4) Teaching (including academic, practical training, specific group instruction, in-service training of psychology personnel and general public lecturing)
(5) Consultation (with governments, community organizations or other individual professionals re mental health)
(6) Research:	
(a) basic
(b) applied
(c) analysis of local service needs and/or facilities
(7) Literature (reading)
(8) Writing (reports, etc.)
(9) Other (please specify)
.....
.....
.....
.....

12. Please list the major types of psychometric *tests* and *assessments* that you perform (e.g. intelligence assessment, measurement of vocational aptitudes and interests, etc.) and give an estimate of the number of each type that you administer for diagnostic purposes in an average week:

Tests and Assessments	No.
(1)
(2)
(3)
(4)
(5)
(6)
(7)
(8)

13. Please give an estimate of the proportion of your treatment time devoted to each of the following:

(1) counselling:%
(2) psychotherapy:—	
(a) group:%
(b) individual:%
(3) behaviour therapy:—	
(a) aversive conditioning:%
(b) anti-anxiety conditioning:%
(c) operant conditioning:%
(d) cognitive & perceptual retraining:%
(4) milieu therapy:%
(5) play therapy:%
(6) hypnosis:%
(7) other:%

14. Using the last twelve months as a representative sample of your work, please rank separately in each of the three columns below, in order of frequency, the types of patients or clients seen whose problems are primarily due to:

Type of Problem	Children	Adolescents	Adults
(1) psychosis:
(2) neurosis:
(3) addiction (drug and alcohol):
(4) sexual deviance:
(5) senescence:
(6) intellectual inadequacy:
(7) social maladjustment:
(8) learning handicap (including perceptual):
(9) organic dysfunction:
(10) other (please specify)
.....
.....
.....

15. How much responsibility do you have in performing the following tasks?
- (1) determining a diagnosis:
- all or most responsibility ☐
- shared responsibility ☐
- little or no responsibility ☐
- (2) determining the course of treatment:
- all or most responsibility ☐
- shared responsibility ☐
- little or no responsibility ☐
- (3) carrying out the course of treatment:
- all or most responsibility ☐
- shared responsibility ☐
- little or no responsibility ☐
- (4) determining own case assignments:
- all or most responsibility ☐
- shared responsibility ☐
- little or no responsibility ☐
16. (a) How frequently do you perform tasks which could be done by someone with less training?
- frequently ☐
- occasionally ☐
- rarely or never ☐
- (b) How frequently are you asked to perform tasks which you do not feel fully qualified to do?
- frequently ☐
- occasionally ☐
- rarely or never ☐
-
17. Do you think that psychologists with clinical training should do some of the work now done by:
- (a) Psychiatrists? Yes ☐ No ☐
- If YES, what specific things do you have in mind?
-
-
- (b) Social Workers? Yes ☐ No ☐
- If YES, what specific things do you have in mind?
-
-
-
18. With regard to their training and legal responsibility, who, in your opinion, should:—
- (a) be allowed to practise psychotherapy?
- (1) social workers ☐
- (2) psychiatrists ☐
- (3) other medical practitioners ☐
- (4) registered psychologists with special clinical training ☐
- (5) registered psychologists ☐
- (b) be responsible for the administration of psychological tests and the interpretation of resulting data?
- (1) social workers ☐
- (2) psychiatrists ☐
- (3) other medical practitioners ☐
- (4) registered psychologists with special clinical training ☐
- (5) registered psychologists ☐
- (6) other ☐

19. (a) How successfully have co-ordination and co-operation been achieved among the different professions in your setting?

successful ☐
 partly successful ☐
 unsuccessful ☐

- (b) What, if any, are the obstacles to more successful co-ordination and co-operation among the professions in your setting?

-
20. On the treatment of a patient or client how frequently do you consult with each of the following?

- (1) Social Workers:

at least once a day ☐
 several times a week ☐
 several times a month ☐
 several times a year ☐
 rarely or never ☐

- (2) Psychiatrists:

at least once a day ☐
 several times a week ☐
 several times a month ☐
 several times a year ☐
 rarely or never ☐

- (3) Other medical practitioners:

at least once a day ☐
 several times a week ☐
 several times a month ☐
 several times a year ☐
 rarely or never ☐

- (4) Other psychologists:

at least once a day ☐
 several times a week ☐
 several times a month ☐
 several times a year ☐
 rarely or never ☐

21. (a) How satisfying do you find consultation about the treatment of a patient or client with these groups?

- (1) Social Workers:

highly satisfying ☐
 fairly satisfying ☐
 unsatisfying ☐

- (2) Psychiatrists:

highly satisfying ☐
 fairly satisfying ☐
 unsatisfying ☐

- (3) Other medical practitioners:

highly satisfying ☐
 fairly satisfying ☐
 unsatisfying ☐

- (4) Other psychologists:

highly satisfying ☐
 fairly satisfying ☐
 unsatisfying ☐

- (b) What do you find satisfying or unsatisfying about consultation with the above?

22. (a) Have you taken any formal courses relevant to your work since obtaining your highest degree in psychology?

Yes ☐ No ☐

- (b) If YES, please list the courses and the organizations offering them:

Course

Organization

.....
.....
.....

23. (a) For the practice of your profession in your present setting, would you benefit now from additional formal courses in the physical or mental health field?

Yes ☐ No ☐

- (b) If YES, what areas would these cover?

24. (a) The existing "Psychologists Registration Act" only restricts the use of the words "psychological", "psychologist" and "psychology". Do you think that persons providing professional psychological services should be licensed so as to make the rendering of similar services by any other person illegal?

Yes ☐ No ☐

- (b) What are your reasons for/against licensure:

25. (a) Do you think that the use of certain psychological testing and behaviour modification techniques should be restricted by law?

Yes ☐ No ☐ No opinion ☐

- (b) If YES, what specific testing and behaviour modification techniques do you have in mind?

26. (a) Should medical insurance schemes cover services provided by professional psychologists without medical referral?

Yes ☐ No ☐ No opinion ☐

- (b) If YES, what types of psychological services should be included in medical insurance schemes?

27. (a) How satisfied are you with the standards that are prescribed for your professional training in graduate schools regarding:

(i) entrance requirements:

Satisfied ☐

Somewhat satisfied ☐

Dissatisfied ☐

(ii) curriculum:

Satisfied ☐

Somewhat satisfied ☐

Dissatisfied ☐

(b) Please list any changes you recommend in the contents of graduate (M.A., Ph.D.) courses (including internship programmes) in your professional training:

28. Are you a member of:

(1) the Canadian Psychological Association?

YES ☐ NO ☐

(2) the Ontario Psychological Association?

YES ☐ NO ☐

29. How often do you attend the meetings and conferences of the associations in your profession?

(1) never attend ☐

(2) very rarely ☐

(3) every few years ☐

(4) about once a year ☐

(5) more than once a year ☐

30. In the past year, have you given talks or led discussions concerning your profession in groups within the community?

YES (how many) ☐

NO ☐

31. In the past three years, have you published articles:

(1) in the clinical area?

YES (how many?) ☐

NO ☐

(2) on a topic concerning your profession?

YES (how many?) ☐

NO ☐

32. It is known that in all professions there are some members who engage in professional behaviour which is disapproved by their colleagues. Please list any behaviour which is disapproved by your profession that has come to your attention in the past year or two:

33. How satisfied are you with each of the following activities of your professional association?

	Satisfied	Somewhat satisfied	Dis- satisfied
(a) defining and clarifying ethical standards:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) enforcing standards and disciplining misconduct:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) providing programmes of continuing education:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) seeking changes in legislation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Please use this space for any comment you want to make (about your profession, this questionnaire, etc.):

Thank you very much for your co-operation in filling out this Questionnaire.
Please return it NOW, in the envelope provided, to:

Charles Hanly, Ph.D., Project Supervisor,
c/o Committee on the Healing Arts,
153 St. Clair Avenue West,
TORONTO 7, Ontario.

At the same time please mail, separately, the *postal card* provided so that we will know who have returned questionnaires.

COMMITTEE ON THE HEALING ARTS
QUESTIONNAIRE ON PSYCHIATRIC SERVICES IN ONTARIO
FOR GENERAL PRACTITIONERS

The information contained in this questionnaire will be held strictly confidential. Figures released will be aggregated. No individual statistics will be used.

1. Medical school attended:

2. Date of graduation from medical school:

3. Dates of any postgraduate courses in psychiatry, with brief description of the course:

.....

.....

.....

4. Location of practice (please check)

In an area with population of over 100,000 ☐

100,000 to 50,000 ☐

50,000 to 15,000 ☐

15,000 or less ☐

5. Number of cases per week:

6. Number of diagnoses of psychiatric illnesses.

(a) psychoses

(b) psychoneuroses

(c) character and behaviour disorders

(d) other

Total

Estimates will be adequate for questions 5-8.

7. (a) Number of above cases treated by physician in his own practice:

(b) Number referred to:

(i) mental hospitals

(ii) general hospitals — psychiatric units

(iii) psychiatric clinics

(iv) psychiatrists in private practice

(v) psychoanalysts in private practice

(vi) psychiatric social workers

(vii) clinical psychologists

(viii) other (specify)

(c) Number not requiring treatment

(d) Number refusing treatment

8. Of cases treated directly by the physician (7 (a) above), what numbers were treated by:

(a) counselling

(b) drugs

(c) other (specify)

9. (a) Assessment of adequacy of psychiatric care in your region:
(please check)

Excellent ☐ Good ☐ Adequate ☐

Inadequate ☐ Grossly Inadequate ☐ None ☐

(b) Assessment of adequacy of psychiatric social work services in your region: (please check)

Excellent ☐ Good ☐ Adequate ☐

Inadequate ☐ Grossly Inadequate ☐ None ☐

(c) Assessment of adequacy of clinical psychology services in your region:
(please check)

Excellent ☐ Good ☐ Adequate ☐

Inadequate ☐ Grossly Inadequate ☐ None ☐

(d) Assessment of adequacy of psychiatric nursing services in your region.
(please check)

Excellent ☐ Good ☐ Adequate ☐

Inadequate ☐ Grossly Inadequate ☐ None ☐

10. General comments:

Your co-operation and assistance in completing this questionnaire is sincerely appreciated. Please return it as soon as possible in the enclosed envelope to:

Professor Charles Hanly, Project Director,
c/o Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario.

At the same time please mail, separately, the postal card provided, so that we will know who have returned questionnaires.

QUESTIONNAIRE ON MENTAL HEALTH SERVICES IN ONTARIO FOR SCHOOL BOARDS, UNIVERSITY HEALTH SERVICES

INSTRUCTIONS:

Please answer each question by *circling the number* of the correct response, or that which most closely reflects your opinion. Where response categories are not provided, please answer as specifically as possible.

Name:

Location:

1. Personnel:

	Number		Aggregate hrs./week	Total interviews per year	Function*				
	full- time	part- time			a	b	1	2	3
a) Physicians:									
fellowship in psychiatry									
certified psychiatrist									
other (specify)									
b) Psychoanalyst									
c) Psychologists:									
Doctor's degree in Psychology									
Master's degree in Psychology									
other (specify)									
d) Psychiatric Social Workers:									
M.S.W. degree									
B.S.W. degree									
other (specify)									
e) Psychiatric Nurses									
f) Special Teachers									
g) Other (specify)									

*Please check column with appropriate function:

- 1) diagnostic: a) primary
 b) ancillary
- 2) therapeutic
- 3) general care
- 4) education

2. a) Number of sessions held per week
- b) Total during year
3. a) Number of cases in 1966-67 school year
- b) Number of students potentially served by above personnel
- c) What is total enrolment in your district?
4. Of those people treated in 1966-67, how many were treated
 - a) for the first time
 - b) in a previous year
5. Number of students diagnosed in 1966-67 as suffering from:
 - a) psychosis
 - b) psychoneurosis
 - c) character & behaviour disorder
 - d) other
6. Number of students in 1966-67 treated by:
 - a) psychotherapy: i) individual
 - ii) group
 - b) psychoanalysis
 - c) counselling: i) individual
 - ii) group
 - d) E.C.T.
 - e) insulin-shock treatment
 - f) drug therapy
 - g) hypnosis
 - h) surgery
 - i) narco-analysis
 - j) behaviour therapies
 - k) other (specify)
7. a) Should child guidance clinics be installed in schools?
 - 1) Yes
 - 2) No
- b) If so, should they play a higher treatment role, leaving hospitals for severe cases?
 - 1) Yes
 - 2) No

8. In your opinion, should a clinical psychologist, by himself, provide
- a) primary diagnosis
 - 1) Yes
 - 2) No
9. a) If answer to 8a) is NO, should a clinical psychologist diagnose only upon referral?
- 1) Yes
 - 2) No
10. In your opinion, should a medical degree be a pre-requisite for
- a) diagnostic work
 - 1) Yes
 - 2) No
 - b) psychotherapy
 - 1) Yes
 - 2) No
 - c) counselling
 - 1) Yes
 - 2) No
11. In your opinion, would a course in family relationships added to the curriculum aid in preventing mental illness?
- 1) Yes
 - 2) No
12. Could such a program be offered by your school in the future?
- 1) Yes
 - 2) No
13. In your opinion, should O.M.S.I.P. cover
- a) clinical psychologists
 - 1) Yes
 - 2) No
 - b) psychiatric social workers
 - 1) Yes
 - 2) No
14. Would this alleviate the mental health problem of insufficient personnel?
- 1) Yes
 - 2) No

15. GENERAL COMMENTS: Please use the remaining space for expressing any further opinions or information about the education and regulation of members of your staff.

16. Position of person who answered questionnaire:

Thank you very much for your co-operation in filling out this questionnaire.

Please return it NOW, in the envelope provided, to:

Professor Charles Hanly,
Committee on the Healing Arts,
153 St. Clair Avenue West,
TORONTO 7, Ontario.

QUESTIONNAIRES WERE SENT TO THE FOLLOWING BOARDS OF EDUCATION

Board of Education	Returned	Not Returned
Area 1, Northwestern Ontario		
Fort William	X	
Port Arthur		X
Area 2, Midnorthern Ontario		
Sault Ste. Marie	X	
Sudbury Public School Board	X	
Area 3, Northeastern Ontario		
Timmins Public School Board	X	
Area 4, Western Ontario		
Chatham	X	
London	X	
St. Thomas Public School Board		X
Sarnia	X	
Windsor	X	
Area 5, Midwestern Ontario		
Brantford	X	
Galt		X
Guelph	X	
Kitchener Public School Board		X
Kitchener-Waterloo High School Board	X	
Stratford		X
Waterloo Public School Board	X	
Woodstock	X	
Area 6, Niagara		
Ancaster Township School Area	X	
Burlington	X	
Hamilton		X
Niagara Falls	X	
Oakville	X	
Port Colborne	X	
St. Catharines	X	
Saltfleet Township School Area	X	
Welland	X	

Board of Education	Returned	Not Returned
Area 7, West Central Ontario		
Barrie Public School Board	X	
Brampton Public School Board	X	
Chinguacousy T.S.A.	X	
Etobicoke	X	
Lakeshore District		X
Toronto	X	
Toronto Township	X	
York		X
Area 8, East Central Ontario		
East York	X	
Leaside		X
North York	X	
Oshawa	X	
Pickering T.S.A. # 2		X
Richmond Hill Public School Board	X	
Scarborough	X	
Whitby Public School Board	X	
York Central D.H.S. Board		X
Area 9, Eastern Ontario		
Bay of Quinte D.H.S. Board	X	
Belleville Public School	X	
Kingston	X	
Peterborough	X	
Trenton	X	
Area 10, Ottawa Valley		
Cornwall Collegiate Inst. Board	X	
Cornwall Public School Board	X	
Nepean Township School Area	X	
Ottawa Public School Board	X	
Ottawa Collegiate Inst. Board	X	

**QUESTIONNAIRE ON PSYCHIATRIC SERVICES IN ONTARIO
FOR OUT-PATIENT CLINICS**

The information contained in this questionnaire will be held strictly confidential. Figures released will be aggregated. No individual statistics will be used.

INSTRUCTIONS:

Please answer each question by **CIRCLING THE NUMBER** of the correct response or that which most closely reflects your opinion. Where response categories are not provided, please answer as specifically as possible.

NAME:

ADDRESS:

AUSPICES UNDER WHICH OPERATED:

DATE:

- 1. Type of patients:
 - 1) adults only
 - 2) children only
 - 3) adults and children

- 2. Number of sessions held per week
- Total number of sessions during the year

3. Personnel:

Functions: *			
1	2	3	4
a	b		

a) physicians: fellowship in psychiatry

certified in psychiatry

other (specify)

b) psychologists: with doctor's degree in psychiatry

with master's degree in psychiatry

other (specify)

c) social workers: with M.S.W. degree

with B.S.W. degree

other (specify)

d) psychiatric nurses

e) child care workers

f) special teachers

g) psychoanalysts

h) other (specify)

*Please check column with appropriate functions:

1 diagnostic: a) primary

b) ancillary

2) therapeutic

3) general care

4) education

4. This unit provides formal training for

No. of Students

1) psychiatrists

2) clinical psychologists

3) psychiatric social workers

4) psychiatric nurses

5) other (specify)

6) none

5. If answer to No. 4 is positive, then, this unit has a teaching staff which is
No. of Staff

1) full-time

2) part-time

6. Please number in order of urgency, your needs with respect to training courses:

..... facilities

..... teachers

..... finance

7. Could training courses be provided at your clinic in the future?

1) Yes

2) No

8. In what fields could your clinic best provide a training course?

1) psychiatric residency

2) clinical psychology

3) psychiatric nursing

4) psychiatric social workers

5) child-care workers

6) special teachers

7) other (specify)

8) none

9. Is there a need for more personnel in child psychiatry?

1) Yes

2) No

10. If there is a need for more personnel, please number in order of urgency:

..... psychiatrists

..... psychoanalysts

..... clinical psychologists

..... psychiatric nurses

..... psychiatric social workers

..... child-care workers

..... special teachers

..... other (specify)

11. Are admissions too complex?

1) Yes

2) No

12. In your opinion, should mental health clinics be under local boards as general medicine, instead of the provincial Department of Health?

1) Yes

2) No

13. In 1966, how many people at your clinic

	a) applied for treatment	b) were treated
children under 5
children 5 — 11
children 12 — 21
adults
total

14. Of those patients treated in 1966, how many were treated

	a) for the first time	b) in a previous year at your clinic or elsewhere
children under 5
children 5 — 11
children 12 — 21
adults

15. Number of patients in 1966 diagnosed as suffering from:

	psychosis	psychoneurosis	character & behaviour disorder	other
children under 5
children 5 — 11
children 12 — 21
adults

16. Number of patients in 1966 treated by:

	ADULTS			CHILDREN			
	total treat- ment hours	under 5	total treat- ment hours	5-11	total treat- ment hours	12-21	total treat- ment hours
psychotherapy:							
i) individual							
ii) group							
psychoanalysis							
counselling:							
i) individual							
ii) group							
electroconvulsive therapy							
insulin-shock treatment							
drug therapy							
hypnosis							
surgery							
narco-analysis							
behaviour therapies							
other (specify)							

17. Does your clinic have a regular programme of evaluation of methods of treatment?

- 1) Yes
- 2) No

18. Does your clinic engage in research into:

- a) causes of psychiatric illness
 - 1) Yes
 - 2) No

b) nature of psychiatric illness

1) Yes

2) No

c) methods of treatment

1) Yes

2) No

19. In your opinion, in what area is the demand for mental health service for children increasing most? (please number in order of urgency)

..... clinics

..... psychiatric units of general or paediatric hospitals

..... provincial hospitals

..... private therapy

..... others (specify)

20. In your opinion, is there a demand for community clinics (as opposed to hospital out-patient clinics)?

1) Yes

2) No

21. Does your clinic provide day care for

a) children 1) Yes age of children

2) No

b) adolescents 1) Yes age of children

2) No

22. If your clinic does *not* provide day care, do you have any immediate plans to do so?

1) Yes

2) No

23. Is your clinic associated with an in-patient programme, as an intermediary stage before the patient returns completely to the community?

1) Yes

2) No

24. Please use the remaining space for expressing any further opinions or information about the education and regulation of members of your clinic:

25. Position of person who answered questionnaire:

Thank you very much for your co-operation in filling out this questionnaire. Please return it NOW, in the envelope provided, to:

Professor Charles Hanly,
Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario

MAILING LIST FOR OUT-PATIENT CLINICS

I. Provincial	Returned	Children & Adults	Children only
1. Brockville			
2. Cedar Springs			
3. East York			
4. Goderich	X	X	
5. Hamilton			
6. Kingston			
7. New Toronto	X	X	
8. North Bay	X (closed)		
9. Owen Sound	X (closed)		
10. Port Arthur	X		X
11. St. Thomas	X	X	
12. Toronto	X	X	
13. Whitby	X	X	
14. Woodstock	X	X	
II. Community:			
15. Belleville General			
16. Chatham M.H. Clinic			
17. Cornwall General	X	X	
18. Hamilton General	X	X	
19. G. Hencks Memorial			
20. Hospital for Sick Children	X		X
21. Weston-Humber Memorial	X	X	
22. Kingston General	X		X
23. Kitchener-Waterloo General	X	X	
24. Northwestern General	X (no out-patient service)		
25. North York General	X	X	
26. Oshawa M.H. Clinic	X	X (Opened 1967)	
27. Ottawa Civic	X (adults only)		
28. Ottawa General	X	X	
29. Peterborough Civic			
30. Ottawa Royal San.	X	X	
31. Queensway General	X	X	
32. St. Catharines General	X	X	
33. Sarnia General			
34. Scarborough M.H. Clinic			
35. Sudbury-Algoma San.			
36. Toronto East General			
37. Toronto General	X	X (children over 16)	
38. London Victoria	X	X (mostly adults)	

Mailing List for Out-Patient Clinics:

II. Community: Continued	Returned	Children & Adults	Children only
39. Welland General			
40. Windsor-Community	X	X	
41. Newmarket-York County	X	X	
42. Borough of York M.H. Clinic	X		X
	<hr/>	<hr/>	<hr/>
Total	28	20	4
	<hr/>	<hr/>	<hr/>

Not included: Clarke Institute

Children's Psychiatric Research Institute

Boys' Village

Thistletown

Ontario Hospital, London

**QUESTIONNAIRE ON MENTAL HEALTH SERVICES IN ONTARIO
FOR IN-PATIENT FACILITIES**

The information contained in this questionnaire will be held strictly confidential. Figures released will be aggregated. No individual statistics will be used.

INSTRUCTIONS:

Please answer each question by circling the number of the correct response or that which most closely reflects your opinion. Where response categories are not provided, please answer as specifically as possible.

Name

Address

.....

Provincial Act under which you are
registered, if any

1. Type of patients:

- 1) adults only
- 2) children only
- 3) adults and children

2. Personnel:

Number		Aggregate hrs./week	Total interviews per year	Function*			
full- time	part- time			1 a	2 b	3	4

a) Physicians:

Fellowship in Psychiatry

Certified Psychiatrist

Other (specify)

b) Psychoanalysts

c) Psychologists:

Doctor's degree in
Psychology

Master's degree in
Psychology

Other (specify)

d) Social Workers:

M.S.W. Degree

B.S.W. Degree

Other (specify)

*Please check column(s) with appropriate function(s):

- 1. Diagnostic: a) primary
 b) ancillary
- 2. Therapeutic
- 3. General care
- 4. Education

3. Does your agency provide training courses in any of the following fields?

- 1) psychiatric residency
- 2) clinical psychology
- 3) psychiatric nursing
- 4) psychiatric social work
- 5) special teaching
- 6) other (specify)

4. Could training courses be provided in the future in any of these fields?

- 1) psychiatric residency
- 2) clinical psychology
- 3) psychiatric nursing
- 4) psychiatric social work
- 5) special teaching
- 6) other (specify)
- 7) none

5. In 1966, how many people

	a) applied for treatment	b) were treated
children under 5		
5-11		
12-21		
adults		
Total		

6. Number of cases in 1966 diagnosed as suffering from:

	Children			Adults
	under 5	5-11	12-21	
psychosis				
psychoneurosis				
character & behaviour disorder				
other (specify)				

7. Number of cases in 1966 treated by:

	Children			Adults
	under 5	5-11	12-21	
psychotherapy:				
i) individual				
ii) group				
psychoanalysis				
counselling:				
i) individual				
ii) group				
E.C.T.				
insulin-shock treatment				
drug therapy				
hypnosis				
surgery				
narco-analysis				
behaviour therapies				
other (specify)				

8. GENERAL COMMENTS: Please use the remaining space for expressing any further opinions or information about the education and regulation of members in your profession:

9. Position of person who answered questionnaire:

Thank you very much for your co-operation in filling out this questionnaire.
Please return it NOW, in the envelope provided, to:

Professor Charles Hanly,
Committee on the Healing Arts,
Toronto 7, Ontario.
153 St. Clair Avenue West,

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